A HEALTH AND WHOLENESS MINISTRY ON THE SAVANNAH SOUTH DISTRICT USING THE HEALTH BELIEF MODEL

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ABSTRACT

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by
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United Theological Seminary, 2017

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This project will address the subject of health and wholeness of ministers and congregants of the Savannah South District of the African Methodist Episcopal Church. To address the problem of health-related diseases and physical inactivity, a Health and Wholeness symposium will be held addressing these various areas of health. The premise is that if these persons are educated and empowered by this training, then they will better take control of a measure of their own health challenges and teach others. This model will utilize the mixed methods research design using pre- and post-surveys to measure the outcome of the project.

ACKNOWLEDGEMENTS

"Blessed are those who trust in the LORD, whose trust is the LORD" (Jer 17:7, NRSV). Lord God, I put my trust in you. I am forever grateful to you for allowing me to accomplish so much, even when I felt so unsure and so unworthy of this great task. I give you all the glory, honor, and praise God, for you held my hand and you saw me through. I thank you and I bless your Holy Name. My trust is in you. Amen.

I am truly indebted for my mentors, Dr. Kenneth Cummings and Dr. Robert Walker. There are no better mentors in any university, anywhere! You have helped me find my voice, tell my story, and do this work in spite of many trials. Words can never repay the two of you for all that you have invested in me and our peer group. I am eternally grateful to you both!

Special thanks to my Professional Associates, Dr. Jonetta Prater, Dr. Carolyn Shorter, and Dr. Kathleen DeJoseph, for your time, talents, and encouragement. I must also give a special thank you my Context Associates: Rosemary Santos, Lee McGee, Raleighetta Varnedoe, Pam Heaggans, Terri Sellers, Yvonne Bradshaw, Rachelle Hughes, Belinda Smith, Taundra Scott, and Ted Brown. Thank you to all of the Health Summit exhibitors and a huge thank you to the Savannah Technical College LPN student volunteers. Thank you to Presiding Elder Catherine Mathis and the Savannah South District for all of your support.

To my peers in the Prophetic Preaching and Praxis Peer Group, past and present, thank you for your encouragement and your prayers. May God be with each of you and bless you all the more for the liberating work that is within you.

DEDICATION

This work is dedicated to the memories of my mother, Rose Elizabeth Grimes Martin, my grandmother, Florence Octavia Grimes, and my eldest sister, Rose Naomi Winmond, three strong black women who loved me without reserve and taught me to stand on my own two feet; to my wonderful husband and number one fan, Rev. Linus R. Robinson, Jr.; to my grandson Donovan Robinson; to my daughter and son-in-law, Rosemary and Ricardo Santos; to my son, Dimonique Robinson; and to my brothers and sisters, Delmar, Charlyene, Wanda, Gerald, and Charles. These are they who keep me grounded and keep me pressing toward the mark.

ABBREVIATIONS

AME	African Methodist Episcopal
AMEC	African Methodist Episcopal Church
CVD	Cardio Vascular Disease
FNP	Family Nurse Practitioner
NRSV	New Revised Standard Version
RD	Registered Dietician

Beloved, I pray all may go well with you and that you may be in good health, just as it is well with your soul.

—3 John 1:2 (NRSV)

INTRODUCTION

The pursuit of theological education in the doctoral program at United Theological Seminary has been one of difficulty for me as I have juggle many ball, or should I say manage many responsibilities beyond that of classes, papers and more classes and papers. Though this journey has been one of ups and downs, the ups have been both great and insightful. This doctoral journey has challenge me in more ways than the academic rigor; it has cause me to look at myself introspectively as I revisit my autobiographical journey against the backdrop of how it intersects with my coming to faith, being nurtured in discipleship and my calling to ministry. It has cause me to take an honest look at myself. This study has also cause me to take a closer look at where I serve in ministry.

I began this program as a lay person who is married to a clergy person and who was deeply involved in the church and ministry where he was assigned. Over the last year, however, my status has changed in the African Methodist Episcopal Church in that I was given the status of licentiate (minister) and assigned to serve a church. This was by no way a burden. Yet, it changed the routine of me traveling with my husband to his church every Sunday to that of me now serving as pastor to a church in a different area twice a month. Again, this journey has been interesting. Now as I draw near to the conclusion of my journey at this institution, it is my hope of presenting in this doctoral thesis much of what I have learned, done and the "whys" behind it.

This thesis (and subsequent project) is entitled “A Health and Wholeness Ministry on the Savannah South District Using the Health Belief Model.” This thesis and project has not come about by happenstance; rather, it unfolded over a period of time through introspection, discernment, prayer and consultation. The rest of this unit will spell out how the chapters (thought processes and project itself) unfolded.

Chapter one, Ministry Focus, speaks to three areas primarily. First, it gives an overview of my life’s journey and faith walk. It begins by pointing out my beginnings, upbringing, schooling, vocation, and the path that led me to ministry. This involves my calling and the process of the ministerial track. It also addresses the gifts and passions that I have for ministry. Secondly, it explores my context of where I serve in ministry. Serving a small membership church in a rural county has its challenges. Yet, serving in a connectional system, the African Methodist Episcopal Church, offers a broader context of ministry. This context has many challenges, one of which is health related. Third, this unit highlights a synergy where my gifts for ministry are wedded with the needs of my context that led to a thesis and project on “health and wholeness.”

Chapter two, Biblical Foundation, undergirds this thesis in how both a passage from the Old Testament and a passage of the New Testament both speak to the subject of health. For the Old Testament passage, I have chosen the text Daniel 1:8, 12-15. This passage was chosen because it speaks to a faithful follower of God subscribing to a healthy diet even under political duress. The New Testament text chosen is 1 Peter 5:1-11. This text speaks to pastors and elders as caring and are charged to watch over the flock and be an example of discipline.

Chapter three, Historical Foundation, traces the historical roots of Methodism of which the African Methodist Episcopal Church is a part. This unit also highlights the enormous contribution that John Wesley, the principle forbearer of Methodism, made to health by his preaching and writings. Many of his books are still used today. This unit also highlights the roles of denominations in establishing hospital and clinics.

Chapter four, Theological Foundation, examines some of the theological framework that speaks to health and wholeness. Practical theology is examined in its contribution of preaching and teaching and its context to health. Liberation theology, more specifically black theology and womanist theology, is examined in how it speaks to issues of health. Soteriology is also examine in how salvation speaks to not only deliverance from sins but also deliverance from unhealthy lifestyles. Lastly, the human condition is examined in how it relates to health.

Chapter five, Theoretical Foundation, is examined in light of how society's cultural dynamics play a role in maintaining health and the health care system. Numbered among the areas explored behind this are politics, race, economics, and gender.

Chapter six, Project Analysis, will address several areas. First, it will restate the thesis' hypothesis. It will also address the methodology used in the project some of which are intervention, research design, measurement and instrumentation. This unit will point out the stakeholders who were a part of this project. As for the project implementation, it will cite collection and analysis of data along with its outcome. Lastly, it will revisit my summary of learning from the school's intensives and focus group sessions. It will conclude with how this project can be replicated in other areas.

CHAPTER ONE

MINISTRY FOCUS

Reflecting upon one's ministerial journey is an enriching experience. Over time, one forgets all that has led one to a particular path, and this review brings with it recollections of life's ups and downs. With it, the review also highlights key areas of focus within one's life. For this author, these focal points include her biographical journey and a review of her context, including a brief review of the origin of the wider contexts of Methodism, American Methodism, the African Methodist Episcopal Church, its journey into the South, and the Savannah South District. Her ministerial journey and her synergy development will follow.

Cheryl Grimes was born and raised in Baltimore, Maryland, the youngest daughter of seven children. She was a tomboy who grew up in the city, complete with the lights, sirens, hustle and bustle, and general busy-ness that makes a city thrive. As the neighborhood defender, she got into her share of fights, but she learned early that if one talked a big game, most people left you alone. It helped that she could fight well, but rarely had to because the other kids knew she could back her mouth up with her fists. Mostly though, her words fought. Cheryl could cut you up with words easily. She loved to read, and that gave her plenty of ammunition. It is amazing how big a bully one can be with very few words. She got along at home though because big words did not work with her even smarter brothers and sisters.

Throughout her youth and young adulthood, Cheryl has always believed in God. She's always understood and believed in his omniscience and his omnipotence. She joined the Army in 1977 and throughout her military career, her faith in God, though tested, continued to grow. Even after retiring from the Army, she has continued to be blessed by and to serve her God.

Context

The local context within which the author is working is as the newly appointed supply pastor of the St. Paul African Methodist Episcopal Church in Black Creek, Georgia. This small rural congregation is located in southeast Georgia, approximately twenty-six miles west of Savannah. The church is a part of the Savannah South District of the Old Georgia Conference of the Sixth Episcopal District of the African Methodist Episcopal Church. The author's contextual focus is the health of African American ministers and congregations in the wider context of this district. Therefore, the Savannah South District is the context that will be used for the doctor of ministry project.

Historical Descriptions

My context is in the larger faith tradition in the family of Methodism. Methodism is a term used to describe "the system of religious faith and practice promoted by John and Charles Wesley and their followers."[1] This system of faith grew out of a friendship among the Wesley brothers and several likeminded friends at Oxford University while

[1] *Oxford Concise Dictionary of the Christian Church*, 3rd ed., (Oxford, UK: Oxford University Press, 2013), 368.

John Wesley served at as a tutor and also as a moderator.[2] This small network of friends met often in

prayer, reading of the scriptures and classic religious tomes, and for regular fasts. After a time, they also began visiting the sick and the incarcerated and doing other charitable acts.[3] Through John Wesley's leadership and example, the small band of friends became a Society known throughout Oxford and the surrounding community. One of the friends called the group "Methodists," because of their frequent meetings and methodical way of life.[4] From 1729 until 1735, Reverend John Wesley continued to lead his small group of Methodist friends in England.

In 1735, the Wesley brothers embarked on a new missional journey to the New World with Colonel James Oglethorpe. John Wesley's time in the New Country was spent serving as priest to the Savannah natives and immigrants. Although his ministry grew in success, he left Savannah after only two years. Despite his abrupt departure, his time in Savannah was instrumental in that it brought the fledgling Methodist ministry, which later became a denomination, to America.

Wesley's return to England saw considerable growth in the Methodist movement over time. This growth led to his organization of groups into societies and classes. There was also the establishment of lay preachers and his inclusion of the poor and females as lay preachers and other leadership positions, as well as his consecration of

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[2] John Telford, *The Life of John Wesley* (New York, NY: Epworth Press, Wesley Heritage Publications, 1924), 62.

[3] Telford, *The Life of John Wesley*, 62-77.

[4] Telford, *The Life of John Wesley*, 64-65.

superintendents. Each of these contributed to the formation of a church separate from the Church of England even though complete separation did not occur until after Wesley's death.[5]

American Methodism

Although similar in some respects, American Methodism was born into the novel culture of a developing country and therefore took a different path to formation than the Methodist Church in England. The major area of difference between English Methodism and American Methodism had to do with the structure of its leadership. This tradition was named the Methodist Episcopal Church because its leaders were ordained as bishops, not as superintendents as they were in England. Over time, the Methodist Church in America grew apart from John Wesley.[6] The lack of ordained ministers and extensive use of lay preachers, the lack of church presence in light of westward expansion, and Wesley's opposition to the independence of the colonies were all contributing factors.[7]

The major similarity between the two was the extensive use of lay preachers, a practice which was begun by Wesley himself. The first Methodists evangelists aside from Wesley and George Whitefield, were laymen and women[8] who began as exhorters and remained in a Society to keep it going where no preacher was available. Many took the

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[5] Justo L. Gonzalez, *The Story of Christianity*: *The Reformation to the Present Day*, Vol. II (San Francisco, CA: Harper One, 2010), 268-73.

[6] Gonzalez, *The Story of Christianity*, 273.

[7] Gonzalez, *The Story of Christianity*, 273.

[8] Robert G. Tuttle, *On Giant Shoulders: The History, Role, and Influence of the Evangelist in the Movement Called Methodism* (Nashville, TN: Discipleship Resources, 1984), 11.

natural step from exhorter to preacher.[9] Wesley developed strict qualifications for them and later began placing them on probation as local itinerant preachers.[10] He assigned one lay preacher to each society.[11]

Francis Asbury brought the itinerant system to America to address the spiritual needs of the early American people.[12] Asbury developed unlearned preachers into a small army of itinerants who traveled and preached in circuits which ranged in size and most covered a very large area.[13]

The African Methodist Episcopal Church

The African Methodist Episcopal Church (AMEC) was formed in a response to mistreatment and bigotry in a climate of slavery and social injustice. The people of the AME Church are from all walks of life, all societal groups, every economic ladder, and hail from nearly every continent. Predominantly, they are people of African descent, with the vast majority living in the United States.

Richard Allen, an itinerant preacher who preached at various meetings and churches along the east coast of America, is the founder of the AME Church. After having been pulled from the alter during prayer, Allen, along with Absalom Jones and

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[9] Tuttle, *On Giant Shoulders*, 11.

[10] Tuttle, *On Giant Shoulders*, 12.

[11] Tuttle, *On Giant Shoulders*, 12.

[12] John Wigger, *American Saint: Francis Asbury and the Methodists* (New York, NY: Oxford University Press, 2009), 3.

[13] Nathan O. Hatch and John H. Wigger, *Methodism and the Shaping of American Culture* (Nashville, TN: Kingswood Books, 2001), 15.

others, led a group of Africans worshiping at St. George's Methodist Church in Philadelphia out of the church to eventually form what is now known as the African Methodist Episcopal Church.

The Savannah South District

The Sixth Episcopal District of the AME Church covers the state of Georgia. As an episcopal distinct, it has over 100,000 members divided among 543 station churches and circuits.[14] These churches are now allocated within six conferences: South Conference, Southwest Conference, Georgia conference, Augusta Conference, Macon Conference and Atlanta North Conference.

The Georgia Conference, also called the Old Georgia Conference because it is the original conference in the state of Georgia, is located in the southeast corner of the state. Until the 2016 General Conference, the Old Georgia Conference was divided into three Districts: Savannah, Savannah West, and Savannah Waycross. Since July of 2016 however, the Conference has been redistricted into two districts: the Savannah North District and the Savannah South District.

Within the Savannah South District are twenty-five churches. Twenty-one of these churches are station churches, each having its own pastor. The other four are in two circuits where two churches are grouped under one pastor who has church services on separate Sundays.[15] Churches in the Savannah South District cover a wide geographical

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[14] Sixth Episcopal District: About us, African Methodist Episcopal Church, accessed March 3, 2014, http://www.ame6.org/aboutus/intro.

[15] *The Doctrine and Discipline of the African Methodist Episcopal Church 2012* (Nashville, TN: The AME Sunday School Union, 2013), 103.

area in Georgia's southeastern corner. These congregations are located in thirteen counties: Appling, Bryan, Bulloch, Burke, Camden, Chatham, Glynn, Liberty, Long, McIntosh, Pierce, Screven, and Wayne. These counties are predominantly rural with five metropolitan areas (urban populations of 50,000 or more) and seven micropolitan areas (rural populations of at least 10,000 but less than 50,000) based on the U.S. Census definitions.[16] The only county in the Savannah South District that has less than 10,000 people is McIntosh county.[17] The metropolitan counties include Bulloch, Camden, Chatham, Glynn, and Liberty. The micropolitan counties are Appling, Bryan, Burke, Long, Pierce, Screven, and Wayne. Within the counties, the churches are located in eighteen cities. Most of these congregations are set in rural areas or in small towns despite the county's designation as a metropolitan or micropolitan area, and range in size from less than ten to congregations of over 300 members. St. Paul AME Church where the author serve is located in Bryan County.

Ministry Journey

Cheryl has been an active member of the AME Church all of her life. She began her Christian journey at Ebenezer AME in Baltimore, Maryland. Cheryl loved going to church. Her mother made her children respect the sanctity of the church and taught them to revere God's House, especially the sanctuary. They went to church to worship, not to play. Rose made sure of that! Cheryl's mother let her kids know that even though God

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[16] Metropolitan and Micropolitan Statistical Areas Main, accessed July 15, 2015, http://www.census.gov/population/metro/.

[17] McIntosh County, Georgia Cities and Counties, accessed September 3, 2016 http://georgia.gov/cities-counties/mcintosh-county.

was always there, they still needed to do hard work; provide for their families; and try to live right. This was Rose's greatest life lesson for her youngest daughter.

Cheryl's grandmother was her biggest spiritual influence as a child. One of her lessons for Cheryl was to pray without ceasing. Granny also taught her that one must know the Word for one's self. Once one does, others are not able to sway them. No matter how others might try, they cannot convince one that God's Word is untrue. Nor can they make one stop "looking to the hills," because you already know where one's help comes from.

The author's ministry journey began in her teen years. Not that she was active in ministry, but this was the point in her life that she remembers questioning the reality/accuracy of the bible. Cheryl had had some class or other that talked about history being written by men and therefore being strictly from their point of view. Her line of thinking after that was, since the bible was written by man (meaning males) who is /are innately flawed, would not what was written also be flawed? Back then she did not know Mark from Adam (pun intended). She did, however, know many men who thought they knew everything and could not wait to tell you all about it. A man was a man, was a man, was a man, in Cheryl's book. And since they lie today, why would anyone think they did not lie back then. Even though a part of her was seriously questioning and searching for answers, Cheryl knew that God's Word is true.

Cheryl entered the United States Army in 1977 after graduation from high school. The first half of her military career Cheryl was as an enlisted soldier and achieved the rank of Staff Sergeant. Her leadership skills were noted from the beginning and she has always been in position of authority. Although she had earned a Bachelor of Arts degree

in Sociology during her enlisted service, she wanted to pursue a degree that was more people oriented. So, in 1987, Cheryl requested a Chapter 16, which is a discharge to go to school. Permission was granted, and she began nursing school that fall.

She earned her bachelor's degree in Nursing in 1991 and returned to active duty as a Second Lieutenant. Becoming a nurse really was the beginning of a new chapter in Cheryl's life, and she believes it was also the beginning of her active spiritual life. She grew up in a Christian family and almost always attended church. Even with a child's limited understanding, she has always believed in God, his omniscience and his omnipotence. She has always been very involved in church organizations and church life wherever she was stationed. However, she really does not think the omnipresent reality of God was something she understood until she became a nurse. In seeing the illness and injuries others faced, Cheryl became very aware of how blessed she was to be happy, healthy, from a decent family, married to a good man, and mother to a beautiful child. God's presence in everyday life was made evident to her. She saw things as she never had before. She became very aware of the spirit of people and how the true person tends to become evident when one is very sick or debilitated.

Whether positive or negative, Cheryl has found that most every patient, family, or situation reminded her of God. She saw God's blessings and His mercies every day. She talked to Jesus when she was feeling overwhelmed with the enormity of how a person's life was impacted by the care she gave. She became more in tune with her own spiritually. Cheryl prayed ALL day long without even thinking about it most days. She felt the Holy Spirit with her whenever she had a really sick patient or one who was dying. She spoke with patient's families in times of sorrow, comforted them, and assured them

of God's goodness. She comforted colleagues in times of stress, confusion and demise. And her colleagues comforted her just as much. Through all that, she got to know God in different ways and became aware of his presence in every action.

God's abiding presence was also more evident within the life of her family and friends. There were several people instrumental to her spiritual growth. Everything they did and everything they taught Cheryl was in support of the ministry and the mission of helping God's people. The work they did was from the heart, not for self-aggrandizement. Their faithfulness and their love were guides for Cheryl as a young woman trying to find her place in the church. Though their lessons for her were many, the details are too long to share in this document. But these lessons included being faithful; getting involved in the church; loving and helping each other; reaching back and bringing someone with you; allowing nothing to be done in the church that does not have God or God's Word in it; understanding that church leadership comes at a price and the price is the time and energy needed to learn the Word of God; and studying to show thyself approved.

While deployed in 2003, Cheryl spent a lot of time just talking to God and she realized how little time she spent in personal worship. This time of private worship and reflection also really helped her to know that she was in that place for a reason and helped her to not dwell on the hardships. It allowed her to see the good they were doing in that faraway place and it increased her resolve to spend more time with her family and with God when she returned.

It was on her return home that Cheryl began to have serious trouble maintaining her weight within the prescribed limits for her sex and age. Cheryl had always had to

struggle to remain within limits prior to her deployment. She had lost a lot of weight while deployed but on her return, it all started piling back on. In addition, she was having issues with her knees which made exercising difficult and required her to wear braces on both knees. Now she could only do the walk event for her physical fitness tests. Even with this modified event, she was barely meeting the fitness standards. All of this was really demoralizing to one who prides herself on her leadership and military bearing.

Despite her weight issues, being home was great! Cheryl had felt good about where she was spiritually until her deployment made her realize that she was still barely touching the surface. She became more active at church and really tried to understand her reason for being. Always an avid learner, she threw herself into bible-study classes, spiritual leadership courses, and spiritual retreats. And while she knew she was doing more, Cheryl also knew it was not enough. She had to fit her study in between work, family, and even church activities; and many times her study was very brief or very shallow. She vowed to do even better when she retired and had more time.

Cheryl retired from the Army Nurse Corps in May of 2004 after a wonderful career of over 26 and a half year's total service. She was blessed with the opportunity to begin a third career as an educator in 2004. Although she did not retire until May 31st, Cheryl was granted permission to become a Clinical Nursing Instructor for Georgia Southern University in January. She also served as an Allied Health Instructor at Savannah Technical College during this time. Cheryl truly loves teaching. Watching students go from "I can't do this" to "I've got this!" is wonderful. And knowing that those students that she taught will be great nurses is as they say: priceless.

While her career and spiritual life were fulfilling, Cheryl continued to have weight issues. Once she retired, she stopped exercising and the weight piled on. At the beginning of 2005, she was diagnosed with high blood pressure. She also began having sleep apnea to the extent that she required a CPAP (continuous positive airway pressure) machine to keep her lungs open while she slept. Then, on her forty-fifth birthday, Cheryl was diagnosed with diabetes. This brought more issues, more medications, and more to do in an already jam-packed life. But God is good! He kept her through all of her issues and even promoted her when she felt so undeserving.

From 2005 through most of 2009, Cheryl continued to work both as an instructor and as a contract nurse. Her weight continued to increase, as did her medical issues. Outside of the obesity, she had diabetes, high blood pressure, high cholesterol, sleep apnea, gastro-esophageal reflux disease (GERD), osteoarthritis, and seasonal allergies. It occurred to her that she was a walking time bomb. It also occurred to her that her whole family, both maternal and paternal, were facing most of the same issues. All of them were different sizes and shapes, from skinny to morbidly obese. Yet all had the same medical issues. In an effort to understand what was happening, she began to study material on obesity and high blood pressure. She found that researchers have been studying this set of disorders called the Metabolic Syndrome for quite some time. Metabolic syndrome is a multicomponent or cluster of risk factors which are precursors to type two diabetes mellitus and cardiovascular disease. This disease syndrome has fascinated Cheryl since she first learned of it, and it continues to be a hot topic for her studies.

In October of 2009, Cheryl became the first civilian Chief of Hospital Education at Winn Army Community Hospital, Ft. Stewart, Georgia. This is her favorite position so

far because it combines elements of each of her personal interest: teaching, nursing, and the ability to help others achieve their goals. Her prayer when she retired was to be able to spend more time with God and more time teaching His Word. This position increased her opportunities to do both. She is closer to home, which means less time on the road to and from work. She also spends less of her own time preparing lesson plans and such for the day ahead.

Cheryl's weight problems persisted. She finally decided that she had to take an active role in getting back to her normal weight and had a Lap-band placed in 2011. This seemed to help at first, but something went very wrong with it one evening and she spent the entire night sitting up in bed vomiting every ten to fifteen minutes. At her surgeon's office the next day, they deflated the Lap-band and had her leave it deflated for a few months to give her stomach a rest period. Although she did get it partially re-inflated one time, she never went back after that. The next year, Cheryl heard about the gastric sleeve. After investigating the process, she went to her provider and asked if it could be done after having the lap-band still in place. He said it could, but that all candidates had to go through several months of classes before they would be eligible. Candidates had exercise classes, nutrition classes, classes on the procedure itself, classes on the pre- and post-operative period, and classes on using various apps to track exercise and intake. Cheryl loved it. The focus was on each person learning how to keep the weight off. They constantly reminded each candidate that the surgery only provides a jump-start. The rest is up to the individual. Cheryl had her procedure in October of 2013 and lost about 30 pounds right away. She was kind of disappointed because some people lost much more weight right off the bat. But at the same time she was grateful. It did give her a jump

start. So far she has lost about ninety pounds. She is trying to lose another fifty pounds by graduation with an ultimate goal of losing a total of one hundred more pounds. This will put her back in her ideal weight range. Cheryl credits her success to God of course, but also, to the program at her hospital. The classes and all of the support activities that reinforced what was learned were awesome. The reality was that these were not new classes or new information. Much of it was information that she has taught her nursing students. But sometimes one thinks one has to re-hear and re-learn. In order for some things to get through to us, one has to make it personal again.

Teaching and learning have been at the core of Cheryl's spiritual growth as well. Although she had not had much in the way of formative religious studies, she loves to learn and loves to teach. She has always been involved in those activities that do at least one, if not both. She has been a Sunday School teacher most of her adult life which, she thinks, is one of the ultimate teaching and learning experiences. She also really enjoys teaching Bible Study and taking classes herself. One cannot teach what one does not know, so one has to study and learn beforehand. Even what one does know, one should at least review.

In November of 2014, Cheryl formalized her call to ministry by preaching her initial sermon, "Are you Hungry Yet?" This marked the beginning of her journey to become an ordained minister in the African Methodist Episcopal Church and to eventually become a pastor. As she prepared for her sermon in the weeks prior to that Sunday, she found herself to be very introspective. How does one who is a nurse evolve into a minister of the Gospel? Other than knowing in her heart and in her spirit that God has called her to preach, what does she have to offer those who are broken and hurting?

Only through much prayer and meditation was she able to realize that her ministry has always had a foundation based on helping and empowering others. As a lay person, her personal ministry was one of encouraging personal growth through teaching and active participation. On the one hand, teaching allows one to show others their growth potential and is the foundation for that growth. As a supply pastor, her ministry is much the same. It involves encouraging and empowering the people of God by teaching them the Word and giving them the tools that will make them successful harvesters.

In the case of her ministry as she moves through the Board of Examiners and onward toward ordination, Cheryl knows that she will be successful because she loves to learn and she loves to share thoughts about the Word and where God is leading. Cheryl loves both preaching and teaching, although she is quite the novice at preaching. But for both, she feels she will be successful if she is able to give you something to think about, mull over, search the Word, and mull over some more. She likes to go beyond just the explanation of the Word to putting the Word into today's context. She wants others to understand what the Word means for one today and why one should care. She also wants to be able to break down the Word and present it in such a manner that one is not only able to relate, but that they want to know more. She wants to give you something to think about which is a reason to come back to the Word.

Whereas teaching is the foundation for growth, active participation is like a nutrient that induces and causes further growth. It is as important to Cheryl's ministry as teaching. As long as one sits along the sidelines, they neither learn nor grow optimally. Once they get in there and start to get involved in their own learning, they begin to allow

themselves to open up. It is very much like the closed fist analogy: you can neither give nor receive as long as your fist and your mind are closed.

Cheryl thinks that where many of today's religious leaders fail is that they are so caught up in their own stylistics and showmanship that they often forget to make it real for the congregation. These ministers do not encourage either thinking or participation from their parishioners. They give the congregation the Word wrapped up in a pretty package and say "Come back next Sunday for more." They cater to one's lazy nature and encourage ministry that allows one to sit either in the pew or at home as unthinking, inactive, non-participatory, do-nothing Christians. Rather than cause growth, this causes stagnation within the church and is the polar opposite of Christ's teaching. It is exactly this lack of participatory learning that Cheryl believes has led our congregations away from the church.

Cheryl's successes in ministry have also been in the area of teaching. This may be because she is comfortable with herself and with others. She relates well to people. People tend to like her because they know that she is an "upfront" type of person. They feel comfortable with her and feel free to ask her to speak or to pray or to otherwise represent them and/or support them. More importantly, those who know her know that Cheryl will not give them a 'feel good' answer. She tries to be open and honest and provide sound guidance. When she gives the Word, whether preaching, teaching or other venue, she studies the Word first. She prays for direction. And she tries to make the congregation, audience, or class think about the Word in order to internalize the Word.

Synergy Development

After a thorough review of her detailed biography and contextual documents, the author concludes that her personal ministry is one of encouraging personal growth, encouraging spiritual growth, and teaching using active participation methods. Encompassing that ministry are two themes: helping others to reach their goals through transformative learning and helping others to develop healthy lifestyles by facilitating change.

Helping Others Reach Their Goals

Helping others reach their goals requires discipline and self-control on the part of both the goal setter and the one attempting to assist. Regardless of the goal, it is a learning process. Learning specific details is a beginning, but the goal will not be attained if the process stops at this point. These same details must be explored and mastered by the goal setter in order for success. Because it is a process, helping others to reach their goals requires more than simply cheering them on.

Transformative Learning

For the adult learner, teaching and learning take place within a wide variety of adult learner roles and occur in a variety of settings, both formal and informal. Transformative learning, as described by Patricia Cranton, is what takes place when “an individual has reflected on assumptions or expectations about what will occur, has found

these assumptions to be faulty, and has revised them."[18] Theoretically, transformative learning is a two-step process. The first step is an active process in which individuals choose to learn and have some level of control over their learning process and their learning environment called self-directed learning.

Critical reflection is the second and key step in transformative learning. Critical reflection is an action oriented process and refers to the intentional self-evaluation of one's ideas, ideals, and knowledge in an effort to derive new meaning from past experiences. Approaches to critical reflection include the articulating assumptions by reflecting on current norms, attitudes, expectations, and traditions. Secondly, one should evaluate when and how these assumptions were formulated. Third, one must explore one's assumptions for both costs and magnitude. Finally, one must assess one's assumptions by using critical questioning to challenge, uncover, and validate current assumption, truths, and views.[19] This process will help to enable one to see alternate paths and solutions and to acquire different skills and viewpoints.

Critical reflection, in and of itself, will not necessarily lead to changes in one's understanding or performance. However, when one allows critical reflection to induce change, transformative learning begins. Critical reflection therefore is the linchpin of transformational learning, so much so, that Cranton describes critical reflection as "the central process in transformative learning".[20]

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[18] Patricia Cranton, *Professional Development as Transformative Learning: Perspectives for Teachers of Adults* (San Francisco, CA: Jossey-Bass, 1996), 2.

[19] Cranton, *Transformative Learning*, 77-79.

[20] Cranton, *Transformative Learning*, 75.

When used effectively, critical reflection fosters personal and spiritual growth by allowing one to articulate assumptions through reflecting on current norms, attitudes, expectations, and traditions. This assists one in determining when and how these assumptions were formulated and allows one to explore the cost and the magnitude one's assumptions have had throughout their life.

Critical reflection and articulation of assumptions need not be thought of as some grandiose, life altering experience. Rather, critical reflection should occur as a part of one's everyday existence. Critical reflection is therefore a continuous activity that is not bound by time, place, activity, or problem. It causes one to alter their view of themselves, their surroundings, their preconceived ideas, and their knowledge base(s). It leads to transformative learning and thereby personal and spiritual growth by bringing erroneous perspectives to one's consciousness. Through this one's adaptation is based on a more accurate view.

Transformative learning then is a process in which one is able to change (or validate) one's interpretation in light of new or other perspectives. By including these other perspectives in one's current framework, learning takes place and one is transformed. This transformation is the ultimate goal of adult learning.

Helping Others to Develop Healthy Lifestyles by Facilitating Change

Helping others to develop healthy lifestyles also requires discipline and self-control on the part of both the goal setter and the one attempting to assist. Unlike goal setting in the strictest form, developing a healthy lifestyle requires more than the actual learning process. Learning and the learning process are integral parts of lifestyle

development or lifestyle change. However, learning is not the only task which must be accomplished. Additionally, as with all change, no one can say for sure that this person or the next will be successful in making a change. This is especially true when one is speaking of lifestyle changes because they usually require change in more than one area. If one is to help facilitate change, one must have some level of understanding as to why the situation occurs in the first place.[21]

Although behavior, and therefore changes in behavior, are seen as "being affected by, and affecting multiple levels of influence, [including]…intrapersonal, or individual factors; interpersonal factors; institutional, or organizational factors; community factors; and public policy factors,"[22] the context of the author primarily focuses on the intrapersonal or individual level.

One of the earliest theories used to examine individual behavior and the effect of change is the Health Belief Model.[23] The Health Belief Model (HBM) focuses on the attitudes and beliefs of individuals in order to predict health behaviors. It has been adapted to explore a variety of long- and short-term health behaviors. The Health Belief Model is based on three assumptions. First, it posits that a person will make health-related change to avoid undesirable disorders or illnesses. Secondly, it theorizes that a person will make health-related change if one expects they will avoid undesirable disorders or illnesses if the suggested action is taken. Third, the HBM hypothesizes that a

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[21] Karen Glanz and Barbara K. Rimer, *Theory at a Glance: A Guide for Health Promotion Practice*. 2nd ed. National Cancer Institute, National Institutes of Health, U.S. Department of Health and Human Services. NIH Pub. No. 05-3896 (Washington, DC: NIH, September 2005), 5.

[22] Karen Glanz, Barbara K. Rimer and Kasisomayajula Viswanath, eds., *Health Behavior and Health Education: Theory, Research, and Practice* (San Francisco, CA: John Wiley & Sons, 2008), 10.

[23] Glanz and Rimer, *Theory at a Glance*, 12.

person will make health-related change if one believes in their ability to effectively complete the suggested action.[24] Use of the Health Belief Model is an important tool when helping others to develop healthy lifestyles because its concepts can help explain why people will (or not) move toward change.[25]

In light of my life journey as a health educator in nursing and minister of the gospel (a bearer of a Word of health and wholeness) against the backdrop of my context as a pastor serving in a certain district, I propose to put forward a symposium on health care. The topic for this doctoral work and symposium name is: "Implementing A Health Ministry: A Healthy Lifestyles and Nutritional Goals Project on the Savannah South District."

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[24] Glanz, Rimer, and Lewis, *Health Behavior and Health Education*, 46-8.

[25] Glanz, Rimer, and Lewis, *Health Behavior and Health Education*, 47.

CHAPTER TWO

BIBLICAL FOUNDATIONS

Introduction

Cardiovascular disease is a predominant source of death and disability in the U.S. Included in the term are several lifestyle behaviors which directly and indirectly affect cardiovascular health leading to a prevalence for heart diseases, heart failure, heart attacks, strokes, and death. African Americans are among the poorest in cardiovascular health in this country, leading the pack in physical inactivity, poor dietary patterns, and obesity. Dietary changes, physical activity, and overall obesity reduction are important factors for reducing these risks. These risks are significantly increased among residents of the stroke belt, which includes the state of Georgia.

The African Methodist Episcopal Church (AMEC) is a historically African American denomination with a tradition of social justice. Its people include members from all over the globe including many of the countries in Africa, Europe, and Asia. This worldwide denomination is called the Connectional Church by its constituents and includes of over 4,100 churches, 6,000 clergy, and 2.5 million members, most of African descent.[1] In the United States, as well as abroad, members are of all ages, occupations, and socioeconomic backgrounds.

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[1] Association of Religion Data Archives, Religious Groups, Methodist/Pietist, African Methodist Episcopal church, accessed, http://www.therarda.com/Denoms/D_937.asp.

Under the umbrella of social justice, it is often the Church[2], either alone, in conjunction with healthcare organizations, or along with researchers, who provides public health services and engage in health promotion activities to alleviate the suffering of those in need.

The AME Church has, since its beginning, been fully immersed in the healthcare of its members as much as it was with its other functions. Indeed, the AME Church, as have other denominations, has not only served in the role of health advocate, it has also been the focal point of social norms and rites. "Black churches have served as houses of worship, schools, meeting places for fraternal organizations, and loci of community organization. The black minister has been teacher, preacher, funeral director, politician, and …agent of health change."[3] In order to maintain its social justice platform, and more importantly, to address the urgent need for healthy lifestyles behaviors, the AME Church must continue to provide the leadership its congregants need, not only spiritually, but physically as well.

The central focus of this research is teaching pastors and their congregations healthy lifestyle behaviors as a model for change. The text of Daniel 1: 8, 12-15 is the Old Testament foundation for this work. [4] This text was chosen because Daniel serves as a model for maintaining healthy behaviors in the Old Testament. He also is an example of

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[2] Church as used in this context includes any religious organization of worship, its clergy and congregation.

[3] Jeffrey S. Levin. "The Role of the Black Church in Community Medicine," *Journal of the National Medical Association*. 76, no. 5 (1984): 478.

[4] Unless otherwise noted, all scripture references in this document are from the *New Revised Standard Version of the Bible*, Division of Christian Education of the National Council of the Churches of Christ in the United States of America (Nashville, TN: Abingdon Press, 2009), used by permission.

discipline. The qualities of this biblical champion are key to the successful adaptation of lifestyle changes for both pastors and their congregations. The New Testament text is 1 Peter 5:1-11. Peter serves to remind pastors and church elders to be caring leaders. He encourages leaders to watch over our members and to be examples to them. Most importantly, Peter serves as a model of faithfulness.

Authorship, Literary Foci and Historical Background

The meaning of the name Daniel is "El is my judge," or simply, "God judges."[5] Daniel is also the given name of a young Israelite pressed into service in King Nebuchadnezzar's court during the Babylonian captivity. He, along with three others, was found to meet the strict criteria set forth by the king: young, no defects, handsome, knowledgeable, insightful, and teachable. Upon placement in the palace, Daniel's name was changed to Belteshazzar. His companions, Hananiah, Mishael, and Azariah, were renamed Shadrach, Meshach, and Abednego. [6]

The stories of Daniel's captivity are very familiar stories for anyone who grew up in the church. "Daniel in the Lion's Den," and the "Three Hebrew Boys and the Fiery Furnace," are early required reading for Christian children of any number of denominations. Because of this, one tends to formulate a certain image of the young Daniel and his friends. One also associates this youth described in the narrative as the writer of the Book of Daniel. This however, does not appear to be the case.

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[5] Sibley Towner, "Daniel," in *The New Interpreter's Dictionary of the Bible, vol 2*, ed. Katherine Doob Sakenfield (Nashville, TN: Abingdon Press, 2007), 11.

[6] Daniel 1: 3-7.

The authorship of the Book of Daniel has long been in question. This is due in part to a lack of cohesiveness of the text. There are several issues that seem to divide the book rather than present it as a unified whole. The first issue has to do with language. Chapters two through seven are written in Aramaic and are seen as the original chapters. The remaining six chapters, including chapter one, are written in Hebrew. These chapters are viewed by some as add-ons to the original book[7] while Tanner[8] describes others who see chapters seven through twelve as the original, with one through six as the add-ons.

Another issue that seems to divide the book is that there are two separate literary foci for the Book of Daniel. The first six chapters are comprised by what has been called the "court stories." Chapters seven through twelve are considered "vision stories."[9] The court stories are narrative in nature and use third person to describe the feats of Daniel and his three friends. The vision stories, on the other hand, are apocalyptic in nature and Daniel speaks in first person as he describes the visions and events that take place.[10]

A third issue in determining authorship is the apparent historical errors that weaved throughout the Book of Daniel. Wiseman details the two pressing historical inaccuracies in the book including the identity of King Darius and the timing given for Nebuchadnezzar's defeat of Jehoiakim.[11] Lopez, on the other hand, states that the

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[7] Daniel L. Smith-Christopher, "The Book of Daniel: Introduction, Commentary, and Reflections," in *The New Interpreter's Bible* (Nashville, TN: Abingdon Press, 1996), 7.

[8] J. Paul Tanner, "The Literary Structure of the Book of Daniel," *Bibliotheca Sacra* 160 (2003): 269.

[9] J. Paul Tanner, "Literary Structure of Daniel," 272.

[10] Kathryn Lopez, "Reading Daniel: Negotiating the Classic Issues of the Book," *Review and Expositor* 109 (2012): 522-3.

[11] D. J. Wiseman, "Some Historical Problems in the Book of Daniel," in *Notes on Some Problems in the Book of Danie*l, ed. D. J. Wiseman, (London, UK: The Tyndale Press, 1965): 9; 16.

understanding of historical events and the advanced writing style are indications that the latter chapters were written after Antiochus IV destroyed the temple in 167 BCE.[12]

These and similar inconsistencies have led many scholars to conclude that the Book of Daniel was not written by Daniel or that it was not written during the sixth century.[13] Some scholars contend that the book is a composite of several books, neatly redacted to what is currently known as the Book of Daniel. Many ascertain that the court stories are fictional,[14] but that the rest of the chapters were written by Daniel. Others contend that the entire book is a work of fiction designed to soothe the Israelites during their tumultuous exile.

Redditt is one author who views the Book of Daniel as a collection of apocalyptic texts written in ten narratives and assembled by Seleucid scribes to fortify and encourage captive Jews. He depicts Daniel as the book's hero, rather than its author. Further, he depicts the Seleucid community as the people for whom the book was written.[15]

Despite these widespread theories, there are those who believe Daniel to be a single work by one author. Bruce uses his work on themes to provide answers to the literary, historical, and linguistic issues which plague the Book of Daniel. He applies this

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[12] Lopez, *Reading Daniel*, 524.

[13] Richard D. Patterson, "Holding on to Daniel's Court," *Journal of the Evangelical Theological Society* 36, no. 4 (1993): 446.

[14] Smith-Christopher, *The Book of Daniel*, xx.

[15] Paul L. Redditt, "The Community Behind the Book of Daniel: Challenges, Hopes, Values, and Its View of God," *Perspectives in Religious Studies* (2009): 331-339.

work to Daniel's narratives to argue for a cohesive theme, that of God's sovereign nature and establishment of an eternal kingdom, to the entire book.[16]

Gooding is also a proponent of a cohesive book. He argues that the analysis of literary structure is a two-level process that is often completed in reverse order, thereby producing inaccurate results. Gooding states that the complete message of any work will never be understood without understanding the first level and cites several scholars who have erroneously labeled the Book of Daniel a composite book. Gooding examines the book using the "correct" order to develop his theory of a book that is a unified whole, written by Daniel, with consistent imagery and themes, and a complete prophetic message.[17]

Regardless of the fence side one places oneself on as it relates to the authorship issues of the Book of Daniel, the character of Daniel as described in the first six chapters, is of most import for this work. The criteria King Nebuchadnezzar demanded were qualities most would seek in any leader of good report. Daniel possessed these qualities and more. He is portrayed as being wise, faithful, and fearless in terms of serving God. As the 'hero' of this set of scriptures, he provides a model for obeying God's word despite the obstacles one may face. These qualities will be needed in order to enable pastoral and congregational lifestyle changes.

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[16] Les P Bruce, "Discourse Theme and the Narratives of Daniel," *Bibliotheca Sacra* 160, no. 638 (April 1, 2003): 186.

[17] David Gooding, "The Literary Structure of the Book of Daniel and Its Implications," *Tyndale Bulletin* 32 (January 1, 1981): 43-79.

Exegesis: Themes of Daniel 1:8; 12-15

As one begins to exegete Daniel 1: 8, 12-15, several themes emerge. These themes are self-control, faithfulness, discipline and victory. Each of these themes are critical to the successful implementation and maintenance of a healthy lifestyle. Each of these themes are also critical strengths for pastors who are willing to model healthy lifestyle behaviors to facilitate healthy lifestyle changes among their congregants.

Self-Control: The Fight against Temptation

The fight with one's self-control has been a popular topic in all forms of media for many years. Muraven and Baumeister define self-control as "the exertion of control over the self by the self."[18] Self-control is often difficult to achieve especially when one lacks motivation or when one feels they are unable to overcome personal and/or environmental difficulties. Self-control may also be harder to achieve when one has outside forces demanding capitulation.

The application of external forces as an inducement may weaken one's ability to fight temptation. Although a plethora of self-help tools exist in modern times, ultimately, one must depend on one's internal fortitude as a defense. Until one has become resolute within one's self, self-control may remain elusive. Resisting persuasive influences today requires both a desire to resist and the determination to refuse capitulation.[19]

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[18] Mark Muraven and Roy F. Baumeister, "Self-Regulation and Depletion of Limited Resources: Does Self-Control Resemble a Muscle?" *Psychological Bulletin* 126, no. 7 (2000): 247.

[19] Edward Burkley, "The Role of Self-Control in Resistance to Persuasion," *Personality and Social Psychology Bulletin* 34 (2008): 419.

The same requirement for self-control may certainly be seen within the text. “But Daniel resolved that he would not defile himself with the royal rations of food and wine. (Daniel 1: 8a)” Here, Daniel, a slave, found himself in the predicament of being instructed to consume food and drink that are culturally unsuitable. This was for two reasons. On one hand, the food and wine from the kings table were first given as a sacrifice to the pagan gods prior to being prepared for the king. Secondly, the foods used and/or the way in which they were prepared rendered them unclean to the Israelites according to their laws.[20]

As a slave, one would be expected to follow any instruction given. His disobedience could very well have cost him his life. Further, since he had been removed from his family to serve in the king’s court, he had no one from his family around to judge his actions.[21] Rather than accept the situation, however, Daniel refused to allow his circumstances to dictate his behavior. He resolved or set his mind on the path that was necessary for him to take. Daniel’s determination allowed him to press toward a more tolerable existence even while in captivity. His self-control helped him to maintain a healthy lifestyle even in the midst of slavery.

Among the many conversations about self-control in today’s media, self-control, as it pertains to diet and exercise, is often referred to as a sub-topic. For Daniel, his self-control enabled him to resist consuming undesirable food even when pressed to do so by the palace official. Likewise, today’s pastors and their parishioners must also activate

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[20] Noah W. Hutchings, *Daniel the Prophet: A Comprehensive Examination of the Prophecies Concerning the Historical and Future Gentile World Empires* (Oklahoma City, OK: Bible Belt Publishing, 2011), 25.

[21] Hutchings, *Daniel the Prophet*, 25.

self-control measures to resist the competing forces that compel overeating and inactivity. The ability to resist influence is a self-control measure that has been noted by Burkley as essential to in order to counter persuasion.[22]

Faithfulness: Doing what is Pleasing in God's Sight

Many Christian and non-Christian alike quote the "faith" scripture found in the Book of Hebrews: "Now faith is the substance of things hoped for, the evidence of things not seen."[23] Faith, however, is more than believing God will provide the intangible. Faith also involves making the sacrifices necessary to do the will of God. Tobit, in the book by the same name, instructs his children in this manner: "So now, my children, I command you, serve God faithfully and do what is pleasing in his sight. Your children are also to be commanded to do what is right and to give alms, and to be mindful of God and to bless his name at all times with sincerity and with all their strength." (Tobit 14: 8-9). This concept may also be gleaned from Paul's letter to the Romans when he exhorts us to be "living sacrifices" and to act according to the one's measure of faith (Romans 12: 1-3).

Faith for Ashpenaz, the court official, is in King Nebuchadnezzar. Although he is sympathetic to Daniel and his comrades, he is unable to operate using "things hoped for" because he believes in the power of the king that he cannot see. His primary concern is his own life rather than the diet of the four youthful foreigners. He tells Daniel this in no uncertain terms in verses 9 and 10: Now God allowed Daniel to receive favor and

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[22] Burkley, *Role of Self-Control*, 429.

[23] Hebrews 11:1. (King James Version used as the example of the more commonly used definition).

compassion from the palace master. The palace master said to Daniel, "I am afraid of my lord the king; he has appointed your food and your drink. If he should see you in poorer condition than the other young men of your own age, you would endanger my head with the king." This declaration showed Daniel where Ashpenaz, the palace official, was and was not willing to sacrifice, and ultimately gave Daniel a clue as to how to overcome Ashpenaz' reticence.

Daniel's desire to do what was pleasing to God overruled the prudence of a slave's obedience to his master's wishes. "[S]o [Daniel] asked the palace master to allow him not to defile himself" (Daniel 1: 8b). Daniel's level of faith allowed him to sacrifice the bounty of the King's table in order to maintain his commitment to doing what was God's will. His sacrifice also included the risk to his very life by even questioning the King's command. It is this type of sacrifice that leads to what Paul calls the "good, and acceptable, and perfect will of God" (Romans 12: 2).

Discipline: Abstinence from Unhealthy Food and Drink

Discipline, from the author's point of view, is the ability and the desire to do what is required and to do it when and how it is necessary for it to be done. This definition, however, might easily be confused with self-control. A more precise definition comes from Dr. Dallas Willard, who defines discipline as "an activity within our power – something we can do – which brings us to a point where we can do what we at present cannot do by direct effort."[24] Discipline encompasses self-control; yet, it is quite different

[24] Dallas Willard, "Spiritual Disciplines, Spiritual Formation, and the Reformation of the Soul," *Journal of Psychology and Theology* 26, no. 1 (1998): 106.

from self-control. However, discipline and self-control are dependent upon one another. One who has little discipline may struggle with self-control, just as one without self-control may find attaining discipline a difficult task. Conversely, one may not achieve self-control without disciplining oneself; likewise, discipline is difficult to achieve without self-control.

Discipline for Daniel was manifested in his desire to obey his Hebrew heritage while in captivity. With discipline, comes predictable results. Just as a disciplined athlete knows that his work will bring a certain level of success in a sport or a certain physique upon working out consistently, so too Daniel understood the health benefits of disciplined eating and drinking. Because he was disciplined, Daniel had already witnessed the results of a vegetarian lifestyle and knew what the results of his fast from meats and drink would be. “Then Daniel asked the guard whom the palace master had appointed over Daniel, Hananiah, Mishael, and Azariah, “Please test your servants for ten days. Let us be given vegetables to eat and water to drink. You can then compare our appearance with the appearance of the young men who eat the royal rations, and deal with your servants according to what you observe” (Daniel 1: 11-13).

Victory: Healthiness as a Result of Wise Choices

Discipline then ensures one of expected results, and at the same time, discipline also changes us. Remaining disciplined over time provides the successes one is seeking when one begins down the path toward change. In due course, these successes become the victory that one seeks.

Daniel's success in altering the diet intended for him and his friends to consume led to the ultimate victory of overall health. This was an internal victory as far as their mental health was concerned because they knew that they would be able to avoid eating foods restricted by the Law of Moses. It would have also been a rich blessing for the spiritual health to Daniel and his comrades because it was a reminder that God remained with them even in their captivity. More importantly, perhaps, was the external/visible victory. "So [the official] agreed to this proposal and tested them for ten days. At the end of ten days it was observed that they appeared better and fatter than all the young men who had been eating the royal rations" (Daniel 1: 14-15). This visible victory was important because it provided concrete evidence of God's blessings to the captive Israelites.

Word Study

In verse 8 the word "defile" is used twice. Daniel told the palace servant of the master (king) that he would not defile himself. The Hebrew word for defile has as its etymology *gaw-al'* which is "a primitive root that is identical with the idea of *freeing*, that is, repudiating; to soil or (figuratively) *desecrate*: pollute, stain."[25]

The word "prove" has several meanings. Some of the more common ways in which one might use the word "prove" include to establish truth, to show something to be correct, and to determine the answer to a problem. According to the Meriam Webster Dictionary, prove can mean:

> to show the existence, truth, or correctness of (something) by using evidence, logic, etc.; to show that (someone or something) has a particular quality, ability,

[25] *Strong's Hebrew and Greek Dictionaries*, "defile, H1315," QuickVerse 8.0.0.

> etc.; to turn out to be; to learn or find out by experience; to test the truth, validity, or genuineness of <the exception proves the rule> <prove a will at probate>; to test the worth or quality of; specifically, to compare against a standard — sometimes used with up or out; to check the correctness of (as an arithmetic result); to establish the existence, truth, or validity of (as by evidence or logic) <prove a theorem> <the charges were never proved in court>; to demonstrate as having a particular quality or worth <the vaccine has been proven effective after years of tests> <proved herself a great actress>; to show (oneself) to be worthy or capable <eager to prove myself in the new job>; or, to turn out especially after trial or test <the new drug proved effective.[26]

Biblically, the use of the words that convey the idea of the word "prove" has been recorded in several of its books of the bible beginning in Genesis. *Strong's Concordance* lists twenty different Hebrew words that are used to convey "prove," including *qadash, cherpah, anah, yakach,* and *yirah*.[27]

Qadash is the most frequently used Hebrew word for the word "prove" in the bible. It means to sanctify, consecrate, or declare holy; it appears one hundred and seventy-five times.[28] As one might expect, it is used multiple times in each book of the Pentateuch, but it is used most in the books of Exodus and Leviticus, having twenty-seven and thirty-one uses respectively. *Qadash* is also used in the other divisions of the Old Testament. In the History Books, *qadash* is used in ten of the twelve books and is used twenty-seven times in 2 Chronicles. In the Poetic Books, it can be found only once, in the Book of Job. In the Prophetic Books, *qadash* is found in the major prophet's books of Isaiah, Jeremiah, and Ezekiel. It is also found in the minor prophet's books including Joel, Micah, Zephaniah, and Haggai.

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[26] Merriam-Webster.com. Merriam-Webster, n.d., "Prove," accessed September 13, 2016, http://www.merriam-webster.com/dictionary/prove.

[27] *Strong's Concordance*, "prove," accessed September 19, 2016, http://biblehub.net/search hebrew.php?q=prove.

[28] *Strong's Concordance*, "prove."

There are several other Hebrew words which mean "prove." The next three most common words are *anah*, *cherpah*, and *yakach*. *Anah*, which means to humble, to afflict, to mistreat, or to violate, occurs eighty-three time in the Old Testament.[29] *Cherpah* has seventy-three Old Testament uses and means to reproach or disgrace.[30] "Prove" is also conveyed in the bible by the Hebrew word *yakach*. This word means to decide, judge, or reprove and is used fifty-nine times.[31]

Another Hebrew word for "prove" is the word *Nasah*. *Nasah* means to test, tempt, or try.[32] Although there are only thirty-six uses of the word *nasah* recorded, it is this use of the word that one finds in the Book of Daniel. It is recorded in chapter one, both in the present and past tense. In verse twelve, Daniel asks the guard to "prove" or test him and the three Hebrew boys on a diet of vegetables and water. Verse fourteen records that they were "proved" for ten days.

It is this idea of testing that runs throughout the first six chapters of the Book of Daniel. Both Daniel and the three Hebrew boys were tested or "proved" together and separately. Each of these tests proved the faith of the Hebrew captives. From the beginning of their captivity, their faith was tested at a very basic level. But in their later tests of faith, their life hangs in the balance. Their first encounter, described above, was a joint test which they passed with flying colors. If fact, they did so well and looked so

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[29] *Strong's Concordance*, "anah," accessed September 19, 2016, http://biblehub.com/hebrew/ strongs_6031.htm.

[30] *Strong's Concordance*, "cherpah," accessed September 19, 2016, http://biblehub.com/hebrew/ strongs_2781.htm.

[31] *Strong's Concordance*, "yakach," accessed September 19, 2016, http://biblehub.com/str/hebrew/ 3198.htm.

[32] *Strong's Concordance*, "nasah," accessed September 19, 2016, http://biblehub.com/str/ hebrew/ 5254.htm#.

good, that Melzar, their guard, gave them vegetables and water for the rest of the time that they were under his watch.[33]

The next "test" comes for Shadrach, Meshach, and Abednego as the three Hebrew boys were called by their captives. Like their joint test with Daniel, this test is somewhat self-imposed. The three boldly chose to follow their Hebrew laws and not bow to anyone aside from God. Once King Nebuchadnezzar heard that they refused to bow and worship the statue of King Nebuchadnezzar when signaled by music to do so, he became outraged and threatened their lives with death by fire.[34] Most reasonable persons would have expected and even encouraged the boys to obey the King and save their lives; but they chose obedience, and therefore were tossed into the fiery furnace.[35] Once again, they passed the test with great success. Not only did they not look or smell like they had been in a fire,[36]but the King praises God, promotes the three Hebrew boys, releases them, and commands that any who blaspheme the God of the Hebrew boys would be cut asunder and have their home destroyed.[37]

Daniel's faith is next tested later in his life under the rule of King Darius. This test involved a plot by his enemies to have him killed. Because he continued to pray and serve his God, Daniel violated a new decree that was brought before the King by Daniel's enemies and was sentenced to death in a den of lions.[38] Rather than being mauled and

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[33] Daniel 1: 16.

[34] Daniel 3: 1-15.

[35] Daniel 3: 16-20.

[36] Daniel 3: 27.

[37] Daniel 3: 29-30.

[38] Daniel 6: 1-16.

killed by the lions, Daniel was protected by an angel. God rescued Daniel and made him more powerful than before.

No Hebrew word for "test" is used in the last two encounters. However, the results of the encounter indicate that they had been tested. In the three Hebrew boys encounter with King Nebuchadnezzar, no word for "test" is used to describe their situation. Yet, King Nebuchadnezzar tells us the exact nature of the test when he declares that they were delivered by their God because they trusted God and disobeyed the King.[39] The boys themselves indicate that there is a test when they tell the King that they had no need to be careful in their answer to him. The Hebrew word *ḥašḥîn* [40] is used here and implies that despite the test, they would not kowtow to the King to save their lives. Likewise, when Daniel survived the lion's den, he tells King Darius that God's angel protected him because he was found innocent in God's sight.[41] Being found innocent, which in Hebrew is the word *zaku*, [42] shows that some type of examination or test occurred for which he had to be judged or tested. Each of the three tests that Daniel and his three Hebrew friends underwent were symbolic of their struggle to maintain their faith and their heritage in the midst of the idolatrous Babylonian society.

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[39] Daniel 3: 28.

[40] *Strong's Concordance,* "hashin," accessed September 23, 2016, http://biblehub.com/hebrew/chashchin_2818.htm.

[41] Daniel 6: 22.

[42] *Strong's Concordance,* "zaku," accessed September 23, 2016, http://biblehub.com/hebrew/zachu_2136.htm.

Background on the Book of First Peter

Simon was a Galilean fisherman who Jesus chose as one of His twelve disciples. At the time of his choosing, Jesus gave him the name Cephas. "[Andrew] brought Simon to Jesus, who looked at him and said, 'You are Simon son of John. You are to be called Cephas' (which is translated Peter)."[43]

The name Simon is Aramaic for "hearing" or "obedient," while Peter is Greek for "rock" or "stone."[44] Helyer asserts that Jesus changed Simon's name in accordance with the Hebrew custom of using a new name to define or project a particular aspect of one's character. As a "rock," Peter, over time, becomes the stalwart disciple on which the other disciples and early Christians can depend.[45]

Like the book of Daniel, the authorship of the I Peter has long been in question. This, despite the fact that the book which is a letter, begins with a salutation from 'Peter:

> Peter, an apostle of Jesus Christ, To the exiles of the Dispersion in Pontus, Galatia, Cappadocia, Asia, and Bithynia, who have been chosen and destined by God the Father and sanctified by the Spirit to be obedient to Jesus Christ and to be sprinkled with his blood: May grace and peace be yours in abundance.[46]

The main issue which has divided biblical scholars is similar to that which is debated in reference to the book of Daniel. Once again, an issue of language is the primary concern. First Peter is written in a polished form of Greek which many authors consider to be well

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[43] John 1:42.

[44] Larry R. Helyer, *The Life and Witness of Peter* (Downers Grove, IL: InterVarsity Press, 2012), 19.

[45] Helyer, *Life and Witness of Peter*, 20-21.

[46] I Peter 1:1-2.

beyond that of an uneducated fisherman.[47] Although Peter spoke Greek,[48] scholars such as Blevin have adopted the view that he could not have written a letter such as this with its advanced level Greek and with its eloquent phrasing and word usage.[49]

Scholars such as Michaels contend that this is a non-issue because Peter could have used an amanuensis or scribe such as Silvanus, Mark or some unknown transcriptionist to write for him.[50] The noted theologian William Barclay is emphatic that this is the case. He notes that the author openly tells us in 1 Peter 5:12 that he wrote through Sylvanus.[51] Barclay further notes that Sylvanus was the perfect choice since he was a leader in the early Church, a close friend to both Peter and Paul, and a Roman citizen who played a key role in several key activities of the early Church.[52]

Others, claim that First Peter was written by a 'Petrine Circle, a school or following of Peter who published his teachings.[53] Indeed, Boring is emphatic that Peter had nothing to do with the letter which bears his name. Instead, he stresses pseudonymity via a Petrine Circle that kept Peter's work in the Roman church alive.[54] Horrell, however,

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[47] David L. Bartlett, "The First Letter of Peter: Introduction, Commentary, and Reflections" in *The New Interpreter's Bible: A Commentary in Twelve Volumes,* Vol XII. ed. Leander E. Keck. (Nashville, TN: Abingdon Press,1998), xx-xx.

[48] Larry R. Helyer, *Life and Witness of Peter,* 109 - 110.

[49] James L. Blevins, "Introduction to 1 Peter," *Review & Expositor* 79 (1982): 401.

[50] J. Ramsey Michaels, "1 Peter," *Word Biblical Commentary* 49. (1988): lxii.

[51] William Barclay, *The Letters of James and Peter,* The New Daily Study Bible (Louisville, KY, Westminster John Knox Press, 2003), 166.

[52] Barclay, *Letters of James and Peter,* 166-167.

[53] David G. Horrell, "The Product of a Petrine Circle? Assessment of the Origin and Character of 1 Peter," *Journal for the Study of the New Testament* 86 (2002): 31-32.

[54] M. Eugene Boring, "First Peter in Recent Study," *Word & World* 24, no. 4 (Fall 2004): 359-361.

while agreeing that the book is a collection of central tenets of the early Church, refutes the Petrine Circle theories.[55]

Richards, in his examination of the text compared to historical documents, favors Peter himself as the writer of the letter. In his close survey of these documents, he rejects the role of Silvanus as Peter's amanuensis. While he notes that Sylvanus *could* have been Peter's scribe, he reminds us that "we should not confuse style with content" by attributing authorship to Sylvanus when there is no solid indication that this was so.[56] Barclay, addresses this by observing that Peter's thoughts are what constitutes the letter. Sylvanus' command of Greek writing gave the letter its elegance.[57]

Another scholar who seems to favor Peter as the author of the first letter in his name is Jobes. Although stopping short of declaring Peter as the author, she show, in her comparative work on Greek syntax that Peter could have been the author. As she states, "the question concerning authorship of 1 Peter really becomes: could someone like Peter have developed proficiency in Greek writing to the level exhibited in the epistle? And therefore, the question of just how 'good' the Greek of 1 Peter is takes center stage."[58] Dr. Jobes' quantitative analysis compares the Greek in First Peter with that of Josephus, Polybus, 1 Thessalonians 1:1 (comparing to Sylvanus), and Hebrews 5-9 (as a sample of

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[55] Horrell, "The Product of a Petrine Circle," 56.

[56] E. Randolph Richards, "Sylvanus was not Peter's Secretary: Theological Bias in Interpreting dia; SilouanouÅ... eßgraya in 1 Peter 5:12," *Journal of the Evangelical Theological Society* 43, no. 3 (September 2000): 432.

[57] Barclay, *Letters of James and Peter*, 167.

[58] Karen H. Jobes, "The Syntax of 1 Peter: Just How Good Is the Greek," *Bulletin for Biblical Research* 13.2 (2003): 161.

well written Greek). Using her objective analysis, she concludes that the syntax of 1 Peter indicates a non-Greek, and therefore, could have been written by Peter.[59]

Another, similar issue, is that of the date when the letter was written. Bartlett submits that the letter was probably written near the end of the first century near 90 CE, if one credits a pseudonymous author.[60] Gregg, on the other hand, in a more recent work, stipulates dates between 70 and 90 CE after reflecting that 1 Peter's use of "Babylon" is indicative of a time after the destruction of the Temple in 70 CE.[61]

One can see that just as in the book of Daniel, there are numerous theories and arguments related to authorship for First Peter. Again however, just as it is for the book of Daniel, it is the character of Peter, more so than its exact place in time and history, or even than its source, that concerns this writer. While Droge describes Peter as being so immensely flawed in the Gospel of John that Jesus calls him "a 'rock' because of his obtuseness and persistent inability to understand [Him],"[62] it is the author's view that Peter's nickname is an indication of his positive character traits. Peter is indeed a flawed individual. Yet, he overcomes his flaws and grows strong in Christ. It is Peter's demonstrated ability to rise above his imperfections that makes him a source of inspiration and instruction for pastors and their congregations.

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[59] Jobes, "The Syntax of 1 Peter," 172.

[60] Bartlett, "First Letter of Peter," np.

[61] Brian Han Gregg, "1 Peter," in *The Blackwell Companion to the New Testament*, ed. David E. Aune (Malden, MA: Wiley-Blackwell, 2010), 583.

[62] Arthur J. Droge, "The Status of Peter in the Fourth Gospel: A Note on John 18:10-11," *Journal of Biblical Literature* 109, no. 2 (June 1, 1990): 307-311.

Themes of First Peter 5: 1-11

The limitations presented in Peter's first epistle are common to each of us in some degree or other. Some tend to stand alone believing in their own self-sufficiency. Others find that they are unable to believe in God's ability to protect them and are therefore unable to stand on His Word. Others still, find that they are unable to see themselves in God's ultimate plan and remain dismayed at their position in life. In First Peter 5: 1-11, these limitations are addressed and in being addressed, they become the themes that one can use to motivate and guide pastors and their congregations. The themes which will be addressed are creating a community ethic, standing on God's Word, and anticipating victory.

Creating a Community Ethic

Believing in our own self-sufficiency is a character flaw of many Christians and non-Christians alike. In this sense, we are like Simon Peter whose deep autonomy made him the abrupt, to the point of being rude, small business owner personified. This same Simon Peter, who in his haste to show his love for Jesus, brashly asserts that he will never leave His side, denies that he even knew Jesus just a short while later.[63]

As a leader, Peter understands the need to create a sense of community as a way to foster teamwork, discipline and *esprit de corps*. His construction of a community motif begins with identifying himself as a part of the group. Peter begins chapter five by proclaiming his membership within the group of church leaders.

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[63] Pheme Perkins, *Peter: Apostle for the Whole Church* (Columbia, SC: University of South Carolina Press, 1994), 18.

> Now as an elder myself and a witness of the sufferings of Christ, as well as one who shares in the glory to be revealed, I exhort the elders among you to tend the flock of God that is in your charge, exercising the oversight, not under compulsion but willingly, as God would have you do it —not for sordid gain but eagerly.[64]

Not only does Peter identify with other leaders in order to set in place a communal ethic, he also uses this as a means to exert a "right order" among the Christian community[65] and its leadership. His acknowledgement of his "fellow elders" identifies the leaders of the Christian community both by position and by status.[66] Peter also begins to lay out his expectations of that leadership. As the leaders of the community, Peter expresses the expectation that his fellow church leaders will take care of the community members and that they will, at the same time, be examples to community members. He instructs the elders not to "lord it over those in [their] charge, but [to] be examples to the flock. And when the chief shepherd appears, [they] will win the crown of glory that never fades away."[67]

As Elliott notes, leadership roles must be undertaken because of God's will, not because of one's desire for self-glorification. He also notes the

> negative-positive antitheses" that delineate the manner in which this leadership should be undertaken: "not because compelled [to do so] but willingly in accord with God; not for shameful gain but eagerly; [and] not as domineering those allotted [to you] but being examples for the flock.[68]

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[64] 1 Peter 5:1-2.

[65] David L. Bartlett, "1 Peter 5:1-11, Caring for the Household of God" in *The New Interpreter's Bible: A Commentary in Twelve Volumes,* vol XII, ed. Leander E. Keck (Nashville, TN: Abingdon Press 1998), np.

[66] D. Edmond Hiebert, "Counsel for Christ's Under-Shepherds: An Exposition of 1 Peter 5: 1-4," *Bibliotheca Sacra* 139 (1982): 331.

[67] 1 Peter 5: 3-4.

[68] John Hall Elliott, "Elders as Leaders in 1 Peter and the Early Church," *Currents in Theology and Mission* 28, no. 6 (December 1, 2001): 555.

Only when position is accepted in this manner will it be blessed by God. Hence, God uses individuals for not self-glory but for the greater cause of the community of faith and the kingdom of God.

Creating a sense of community and embracing one's members will be necessary in order to remove barriers and decrease any stigma that congregants may associate with physical activity and nutrition. Pastors must be ready to commit to the planned activities and directions. As the church elder, they must be ready and willing to lead by example.

Peter also instructs the members on followership. At the beginning of verse five, he coaches younger or newer members[69] to obey their leaders who are older and wiser. "In the same way, you who are younger must accept the authority of the elders." In other words, church members must be ready and willing to follow the examples and the leadership of their pastors.

Peter continues in verse five and six by encouraging both the leaders and the members not to be arrogant or conceited. "And all of you must clothe yourselves with humility in your dealings with one another, for "God opposes the proud, but gives grace to the humble." Humble yourselves therefore under the mighty hand of God, so that he may exalt you in due time." Everyone is to follow Christ's example of humility.[70]

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[69] Elliott, "Elders as Leaders," 552.

[70] Elliott, "Elders as Leaders," 556.

Standing on God's Word

Standing on God's Word is a difficult task for many. Even staunch believers may find themselves believing God's promises in relation to others but are unable to have the same confidence relative to their own situations. They encourage others to believe that God can do all things. Yet, they are unable to except that He can do all things when it comes to their trials and circumstances.

Because of their unbelief, many face life with fear and trepidation. They carry with them a myriad of worries on a daily basis. Peter however, encourages everyone to stand on God's Word. In verse seven of chapter five, he says to "cast all your anxiety on him, because he cares for you." Standing on God's Word requires that one relinquish all those things which hinder full dependence on God. In order to stand on God's Word, one must begin by surrendering all worries to God.

Additionally, one must submit to the call to faithfulness. Peter instructs that one must know that the adversary will look for ways to move you from your path. Therefore, one must remain vigilant. This will require a constant awareness and total self-control. "Discipline yourselves, keep alert. Like a roaring lion your adversary the devil prowls around, looking for someone to devour. Resist him, steadfast in your faith, for you know that your brothers and sisters in all the world are undergoing the same kinds of suffering.[71] Peter also reminds us that Satan is as persistent as he is devious. Therefore, it behooves one to remain unwavering and not allow the devil to cause you to falter. The

[71] 1 Peter 5: 8-9.

key to resistance is faithfulness, and it becomes easier when one knows that they are not alone in their trials.

Making changes to one's lifestyle requires learning new ways of doing routine tasks. It also requires learning new tasks and getting rid of old habits. If one is unable to believe in God's Word as truth for oneself, these tasks will be difficult, if not impossible. Pastors and congregants alike must be ready to stand on God's Word by letting go of their fears and by answering the call to faithfulness.

Anticipating Victory

After Peter admonishes us to remain faithful, he reminds us that "after [we] have suffered for a little while, the God of all grace, who has called [us] to his eternal glory in Christ, will himself restore, support, strengthen, and establish [us]. To him be the power forever and ever. Amen."[72] As members of the community of faith, we must always be in a preparatory mode for victory! Both the Old and the New Testaments are replete with examples of victory for the faithful. But Peter encourages us by reiterating to us that it is God Himself who will supply our victory. Not only will He restore, support, strengthen, and establish us, he will have us join Him in glory.

Understanding that the victory is already ours, both now and in eternity, increases our motivation as we work toward that victory. Anticipating victory makes the work of getting there less onerous, less taxing, and more joy-filled. As pastors and their congregations anticipate victory in achieving their goals in becoming healthier, they will be motivated that much more to push themselves and each other to achievement.

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[72] 1 Peter 5: 10-11.

Conclusion

Both Daniel and Peter provide inspiration and examples for pastors and their congregations for developing and maintaining healthy lifestyles. This text, Daniel 1:8, 12-15, presents the themes of self-control, faithfulness, discipline and victory. Self-control is recognized as one's fight to overcome temptation. Those who lack motivation, are unable or unwilling to subdue personal and/or environmental difficulties, or who are unable to prevail against outside forces will continue to fight to garner and/or maintain self-control. One must become resolute in order to maintain self-control and defeat temptation. One must have both the desire to resist persuasive influences and the determination not to give in to them.

Faithfulness is more than the simple belief that God will provide. It encompasses a willingness to sacrifice for one's beliefs. Also included is the ability to act or behave at a level commensurate with one's faith. Behaving at the level of one's faith means believing that God will provide (or not) according to His will, but knowing that one must operate within His will for us. This will allow one to do God's will regardless of the potential outcome.

Discipline and self-control are required to get the desired results. These results are predictable, but will also be noticeable. Therefore, with discipline, one is sure to obtain the expected results; and at the same time, one is sure to be changed. The change is both an internal and an external victory. The internal victory bolsters one's spirit. The external victory provides evidence of God's favor and grace.

In 1 Peter 5:1-11, one is able to find the themes of creating a community ethic, standing on God's Word, and anticipating victory. Creating a community ethic fosters

teamwork, discipline and *esprit de corps*. Peter creates a community ethic by identifying key leaders in the group and establishing order. These leaders are placed to care for the community and do God's will. They are not in place for their one glory. Along with good leaders, Peter reminds one that they must be a good follower who encourages the leadership. Both leaders and followers must remain humble.

In standing on God's Word, one begins by letting go of their cares and worries and allowing God to take control. By submitting to God and constantly acknowledging that He is always with one, one is able to maintain self-control and remain faithful to Him. Victory then is assured and can be anticipated and even celebrated.

Congregants of the AME Church are included in the number of those suffering and dying for lack of knowledge and lack of focus. Our calling is to return to our social justice roots and move from a health paradigm of disease treatment to one of disease prevention. The themes found in Daniel 1: 8, 12-15 and I Peter 5:1-11, which overlap in many ways, will serve as encouragement for both congregants and pastors for the journey toward developing and maintaining healthy lifestyles changes.

Pastors are in the perfect position to affect this transition for their congregations. Jesus taught us that sheep follow their shepherd. They know his voice and follow his lead. In the context of today's church, this is also true. Congregations follow where their pastors lead. As leaders of the church, they are empowered to lead and also to heal. In the book of Matthew, Jesus gives a clear mandate to heal his people. Providing tools that will engage pastors and their congregations in lifestyle management will ultimately begin the healing process.

CHAPTER THREE

HISTORICAL FOUNDATIONS

Introduction

The researcher's current context is concentrated within the African Methodist Episcopal Church. More specifically, her contextual focus is the health of the people within the South Savannah District of the Georgia Conference of the Sixth Episcopal District within the African Methodist Episcopal Church. Her overall goal is to teach pastors and their congregants healthy lifestyle behaviors as a means to begin the change necessary to move toward optimal cardiovascular health.

The history of medicine is an extensive topic which encompasses many different subtopics. Globally, the history of medicine is often tracked from biblical times. Histories range from those which discuss specific historical time periods or ages to those which relay the history of specific diseases. Others track the rise or advancement of medical knowledge and the technological advancements that arose in conjunction with that knowledge. Still others recount the negative aspects of medical history including the failures of public institutions, the rise of drug addiction to prescription medications, the lack of cost containment in managed care organizations, and the inability of medical providers to find cures for cancer, HIV, and various other diseases of the modern world.

The concept of health is also a very extensive topic. Health has many different meanings depending on the connotation of the user. These include general wellness, quality of life, and absence of disease. Health may also be seen as one's ability to access healthcare. On a larger scale, the health of a country's population is seen as a measure of its prosperity. Rather than attempt to discuss these extensive concepts in their entirety, this document seeks to provide a brief spotlight on the history of health and wellness in the Wesleyan tradition.

Using the World Health Organization (WHO) definition, health in this framework will be defined as "a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity."[1] This generalized definition is used because it is the most widely accepted definition globally. As of the 2014 edition of the WHO Constitution, 197 member and associate member countries, states, and territories, along with twelve intergovernmental organizations, including the United States and the United Nations, accepted this definition as a part of their constitution.[2]

Wellness will be defined as "a multidimensional state of describing the existence of positive health in an individual as exemplified by quality of life and a sense of well-being."[3] This definition from the President's Council on Physical Fitness and Sports,

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[1] World Health Organization, "Constitution of the World Health Organization in Basic Documents," Forty-Eighth edition, (Geneva, Switzerland: WHO Press, 2014), 1.

[2] World Health Organization, "Constitution of the World Health Organization in Basic Documents."

[3] Charles B. Corbin and Robert P. Pangrazi, "Toward a Uniform Definition of Wellness: A Commentary," *President's Council on Physical Fitness and Sports Research Digest* 3 (15) (December 2001), 1.

acknowledges that wellness is a positive part of health, thereby affirming that health and wellness go hand in hand.

Since the goal is an understanding of the history of American health and wellness as it relates to ministry, particularly in the Methodist tradition, this historical review will begin with an overview of Methodism and American Methodism, followed by a review of health and wellness in John Wesley's ministry. Next will be a brief overview of the development of healthcare institutions in early America, followed by a summary of current American healthcare institutions. Finally, other roles that the Church plays in providing or facilitating health and healthcare will be discussed.

Methodism

In order to understand the Methodist or Wesleyan Tradition, one must first have a broad understanding of Methodism itself. Methodism is a term used to describe "the system of religious faith and practice promoted by John and Charles Wesley and their followers."[4] This "system of faith" grew out of a friendship among the Wesley brothers and several likeminded friends at Oxford University while John Wesley served at as a tutor and also as a moderator.[5] This small network of friends met often in prayer, reading of the scriptures and classic religious tomes, and for regular fasts. After a time, they also began visiting the sick and the incarcerated and doing other charitable acts.[6] Through

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[4] *Oxford Concise Dictionary of the Christian Church*, 3rd edition, ed. E. A. Livingstone (Oxford, UK: Oxford University Press, 2013), 368.

[5] John Telford, *The Life of John Wesley* (New York, NY: Epworth Press, Wesley Heritage Publications, 1924), 62.

[6] Telford, *The Life of John Wesley*, 62-77.

John Wesley's leadership and example, the small band of friends became a Society known throughout Oxford and the surrounding community. One of the friends called the group Methodists, because of their frequent meetings and methodical way of life.[7] From 1729 until 1735, Reverend John Wesley continued to lead his small group of Methodist friends in England.

In 1735, the brothers Wesley embarked on a new missional journey. They boarded the *Simmonds* and headed to the New World with Colonel James Oglethorpe. With them, were a few of their friends, a number of poor Englishmen released from debtors prison, and a small group of Moravians. These were the fifth wave of emigrants to join others who had already made the trek to Savannah, Georgia, as the new colony was called.[8]

John Wesley's time in the New Country was spent serving as priest to the Savannah natives and immigrants. Although his ministry grew in success, he soon found himself at odds with the local magistrate over his withholding of communion to the magistrate's niece who refused to repent of her bad behavior.[9] This episode went downhill quickly for John Wesley and caused him to abruptly leave Savannah after only two years.

Despite his abrupt departure, the two years spent in Savannah were instrumental in that they brought the fledgling Methodist ministry, which later became a

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[7] Telford, *The Life of John Wesley*, 64-5.

[8] Telford, *The Life of John Wesley*, 77-78.

[9] Telford, *The Life of John Wesley*, 80-91.

denomination, to America. Wesley's return to England saw considerable growth in the Methodist movement over time. This growth led to his organization of groups into societies and classes, his institution of lay preachers, and his inclusion of the poor and females as lay preachers and other leadership positions, as well as his consecration of superintendents. Each of these contributed to the formation of a church separate from the Church of England even though complete separation did not occur until after John Wesley's death.[10]

American Methodism

Although similar in some respects, American Methodism was born into the novel culture of a developing country and therefore took a different path to formation than the Methodist Church in England. The major similarity between the two was the extensive use of lay preachers. This was a practice which was actually begun by Wesley himself. Wesley and George Whitefield were both ordained clergy. Aside from these two, the first Methodists evangelists were laymen and women.[11] Although they began as exhorters, many of these were lay persons left to preserve a Society and keep it going where no preacher was available. They then took the natural step from exhorter to preacher.[12] The first of these lay exhorters to preacher changeovers was Thomas Maxfield.[13] Wesley was

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[10] Justo L. Gonzalez, *The Story of Christianity, Vol II: The Reformation to the Present Day*(San Francisco, CA: Harper One, 2010), 268-273.

[11] Robert G. Tuttle, *On Giant Shoulders: The History, Role, and Influence of the Evangelist in the Movement Called Methodism* (Nashville, TN: Discipleship Resources, 1984), 11.

[12] Tuttle, *On Giant Shoulders*, 11.

[13] Tuttle, *On Giant Shoulders*, 11-12. See also Notes for Chapter Two (p. 129) for explanation of Maxfield as first lay preacher; also for use of preacher and exhorter interchangeably.

antagonistic towards this transformation initially until prompted by his mother to hear Maxfield preach. Once he realized the calling God had placed within Maxfield, Wesley decided to use other lay preachers and assigned one to each society.[14] Wesley developed strict qualifications for them and later began placing them on probation as local itinerant preachers.[15]

The itinerant system worked well for Wesley in England, but it was Francis Asbury who brought the system to America. As the only licensed Methodist clergy to remain in the colonies during the American Revolution, Asbury was in a unique position to gage the spiritual needs of the early American people.[16] To address these needs, Asbury developed unlearned preachers into a small army of itinerants who traveled and preached in circuits.[17] Circuits ranged in size, but most covered a very large area. Methodist theologian Dr. Robert Tuttle noted that "some [circuits were] as large as states [and that itinerant preachers] preached in societies… [En]route between societies, [they] preached in taverns, inns, barnyards, jails, courthouses, or just a clearing in the woods. Any place was sufficient as long as it would support a "crowd" of five or ten hearers."[18]

In America, the denomination became the Methodist Episcopal Church (MEC) and grew apart from John Wesley.[19] Several factors caused this schism. In America,

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[14] Tuttle, *On Giant Shoulders*, 12.

[15] Tuttle, *On Giant Shoulders*, 12.

[16] John Wigger, *American Saint: Francis Asbury and the Methodists* (New York, NY: Oxford University Press, 2009), 3.

[17] Nathan O. Hatch and John H. Wigger, *Methodism and the Shaping of American Culture* (Nashville, TN: Kingswood Books, 2001), 15.

[18] Tuttle, *On Giant Shoulders*, 53.

[19] Gonzalez, *The Story of Christianity*, 273.

church leaders were ordained as bishops, not as superintendents. Within the itinerant system, lay preachers were able to practice their craft without becoming ordained. The lack of ordained ministers and extensive use of lay preachers, the lack of church presence in light of westward expansion, and Wesley's opposition to the independence of the colonies were all contributing factors.[20]

The Methodist Episcopal Church has undergone several changes to its structure since the Wesleys first brought Methodism to America. These changes led to the establishment of the Republican Methodist Church, which later became the Christian Church.[21] Another faction, led by James O'Kelly, left the MEC to form the Methodist Protestant Church in 1830.[22] Another split occurred over the desire to speak German. This branch, under the leadership of Jacob Albright, left the MEC in 1803, forming the Evangelical Association. This splinter group later joined the United Brethren to become the Evangelical United Brethren Church.[23] In 1968, these splinter groups reunited with the Methodist Church to create the United Methodist Church.[24]

Likewise, a number of denominations can be attributed to the MEC because of disputes within its ranks. These divisions were for a variety of reasons including racial discrimination, opposition to Bishop Asbury, the Church's stance on slavery, political

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[20] Gonzalez, *The Story of Christianity*, 273.

[21] Richard Wentz, *American Religious Traditions: The Shaping of Religion in the United States* (Minneapolis, MN: Fortress Press, 2003), 180.

[22] Wentz, *American Religious Traditions*, 180.

[23] Wentz, *American Religious Traditions*, 182.

[24] Wentz, *American Religious Traditions*, 182.

and doctrinal issues.[25] Early rifts within the MEC led to the initiation of denominations that remained separate from the MEC. The African Methodist Episcopal Church and the African Methodist Episcopal Zion Church were established to meet the needs of former slaves seeking religious freedom.[26] Both of these denominations continue to have a majority African American population. Another predominately African denomination is the Christian Methodist Episcopal Church. Formerly called the Colored Methodist Episcopal Church, this denomination split from the Methodist Episcopal Church, South to obtain religious freedom as well.[27] Although not considered Protestant churches, churches from the holiness movement and the Pentecostal movement also have their origins in the Wesleyan tradition.[28] The holiness movement, which includes the Church of the Nazarene, Pilgrim Holiness Church, Christian and Missionary Alliance and The Church of God denominations, grew out of the Methodist Church's revivalist period.[29] The Pentecostal movement includes denominations such as the Assemblies of God, Pentecostal Holiness Church, and Foursquare Gospel Church.[30]

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[25] Wentz, *American Religious Traditions*, 180-182.

[26] Wentz, *American Religious Traditions*, 180.

[27] Wentz, *American Religious Traditions*, 181.

[28] Wentz, *American Religious Traditions*, 330.

[29] Wentz, *American Religious Traditions*, 326-327.

[30] Wentz, *American Religious Traditions*, 327-331.

Health and Wellness in John Wesley's Ministry

Much of John Wesley's teaching and preaching centered on physical health and wholeness. Wesley certainly had his own health issues during his adult life. He suffered severe bouts of nose bleeding during early college years[31] and continued having issues with vomiting blood throughout his Oxford days.[32] But Wesley's interest in health extended beyond his own medical complaints. His deeply rooted conviction was that God cared for the whole of his creation, not just delivering from sin, but also preserving and returning his creatures to healthiness.[33]

Wesley's childhood training in his father's parsonage included the belief that pastors cared for their parishioner's health as well as their souls[34] and his preparation for the priesthood included instruction of providing medical care for his flock.[35] His passion for caring for the sick was evident even during his days at Oxford, during which time he and his friends visited the sick on a weekly basis.[36] Wesley continued his physical care of the sick throughout his lifetime. He was also a prolific writer on health and wellness

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[31] Telford, *Life of Wesley*, 45-46.

[32] Telford, *Life of Wesley*, 74.

[33] Randy L. Maddox, "Reclaiming the Eccentric Parent: Methodist Reception of John Wesley's Interest in Medicine," in *Inward and Outward Health: John Wesley's Holistic Concept of Medical Science, the Environment and Holy Living*, ed. Deborah Madden (London, UK: Epworth Methodist Church House, 2008), 15-17.

[34] Maddox, "Reclaiming the Eccentric Parent," 15-16.

[35] Maddox, "Reclaiming the Eccentric Parent," 17.

[36] Telford, *Life of Wesley*, 66.

matters. Wesley's diaries[37] and letters[38] detail his study of current medical literature. He also published health and wellness leaflets and books beginning with *A Collection of Receits* in 1745 through *An Estimate of the Present Manners and Times* in 1782. Wesley continued to provide information on health, remedies, medications, and cures for disease.[39]

One of the most noted of his written works on health and wholeness was the *Primitive Physick.* Although Wesley was criticized as offering "quack" medicine by both physicians and ministers alike, Wesley's *Primitive Physick* was a much sought after booklet. Even after his death, ministers such as John Stamp of the British Church mocked Wesley in the Wesleyan Methodist Magazine.[40] Yet, much of Wesley's information came from the current medical literature of the day. Theologian Randy Maddox notes that Wesley cited nearly a hundred medical documents in his lifetime.[41] Wesley's emphasis in *Primitive Physick* was a healthy lifestyle, including fresh air, physical activity, rest, and small meals.[42] His goal was a pamphlet[43] that was within the means of poor families.[44] The information was provided in a simple, easily readable format. It contained hundreds

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[37] Maddox, "Reclaiming the Eccentric Parent," 16.

[38] Maddox, "Reclaiming the Eccentric Parent," 17.

[39] Maddox, "Reclaiming the Eccentric Parent," 18-19.

[40] Maddox, "Reclaiming the Eccentric Parent," 15.

[41] Randy L. Maddox, "John Wesley on Holistic Health and Healing," *Methodist History* 46, no. 1 (2007): 5.

[42] Maddox, "John Wesley on Holistic Health and Healing," 15-22.

[43] Philip W. Ott, "John Wesley on Health and Wholeness," *Journal of Religion and Health* 30, no. 1 (March 1991): 46-55.

[44] Maddox, "Reclaiming the Eccentric Parent," 19.

of remedies for common diseases and was "designed to empower patients to heal themselves" and provide information on medicines that were safe, inexpensive, and easy to obtain.[45]

Health Institutions Developed by the Church in Early America

Even before there were hospitals in America, the people of the Christian faith have been involved in health and health care. As early as 1727, nuns came to the colonies to nurse and teach African and Native American females.[46] While the United States was still fledgling colonies, the care of the sick was largely undertaken in their homes by their relatives. This was especially true of those with any financial means who were deemed "respectable" in nature.[47] For many, however, home care was not available. Those who were too old, too poor, too feeble, or just too sick, were often cared for in almshouses. These almshouses were, for all intents and purposes, hospitals.[48]

It was not until the late 1700s that the first hospitals for in-patient care were built in America. Even then, there were only two such facilities. The first was the Pennsylvania Hospital in Philadelphia, which was established in 1752. The second was Massachusetts General Hospital in Boston, which was established in 1771.[49] Although

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[45] Deborah Madden, *Wesley as Advisor on Health and Healing* (New York, NY: Cambridge University Press, 2010), 179-182.

[46] Suzy Farren, *A Call to Care: The Women who Built Catholic Healthcare in America* (St. Louis, MO: The Catholic Association of the United States, 1996), iii.

[47] Charles E. Rosenberg, *The Care of Strangers: The Rise of America's Hospital System* (Baltimore, MD: Johns Hopkins University Press, 1987), 4.

[48] Charles E. Rosenberg, *The Care of Strangers*, 4.

[49] Charles E. Rosenberg, *The Care of Strangers*, 18.

these first hospitals received in-patients, their primary function was to keep the infectious, poor, elderly, homeless, abandoned, or otherwise disenfranchised citizens away from the populous. These facilities also frequently became institutions for the mentally unstable.[50]

The poor living conditions and lack of any real medical care within these early hospitals prompted religious outreach. Both Catholic and Protestant denominations began outreach missions within existing facilities. Nursing care administered by these groups set the standard for the treatment of patients and were the foundation for nursing education.[51]

Another impetus for the growth of hospitals in America was the Civil War. The inadequacies of Almshouses and home care became apparent early on for both Union and Confederate forces.[52] Both sides found that equipment, supplies and personnel were limited resources. However, these needs were met on both sides of the Mason-Dixon Line through the implementation of European models of medical care.[53] Not only did the number of hospital facilities increase, medical practices and scientific advances, coupled with modern ideas in sanitation and organization, brought further progresses to the sick

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[50] Harry A Sultz and Kristina M. Young, *Health Care USA: Understanding its Organization and Delivery*, 7th ed (Sudbury, MA: Jones & Bartlett Learning, 2006), 71.

[51] Sultz, and Young, *Health Care USA*, 71-2.

[52] Rosenberg, *The Care of Strangers*, 97.

[53] Rosenberg, *The Care of Strangers*, 97.

and injured in Civil War era hospitals. There were nearly 137,000 beds spread out in over two hundred Union hospitals alone by the end of the Civil War.[54]

Another characteristic of early American hospitals was that they were located in large, well populated city centers. Within one hundred years of the first two hospitals' establishment, the number of hospitals in the country grew steadily. Many of these novice facilities were launched by the religious community. For example, in New York alone, five new facilities were established by religious denominations. These included St. Vincent's (Catholic, 1849), St. Luke's (Episcopal, 1850), Mt. Sinai (Jewish, 1852), St. Francis (Catholic, 1865), and Presbyterian Hospital (1868).[55]

Current American Healthcare Institutions

Today, the tradition of hospitals and healthcare by religious organizations continues to flourish. Law professor Michael DeBoer notes that "an array of religious traditions and denominations (both Christian and non-Christian) have sponsored hospitals, including the Baptist, Catholic, Episcopal, Jewish, Latter-day Saints (Mormon), Lutheran, Methodist, Presbyterian, and Seventh-day Adventist traditions."[56] These healthcare organizations serve communities all over the United States and provide care for a sizeable portion of the population. For instance, 624 hospitals, or one of every eight

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[54] Rosenberg, *The Care of Strangers*, 97.

[55] Rosenberg, *The Care of Strangers*, 109.

[56] Michael J. DeBoer, "Religious Hospitals and the Federal Community Benefit Standard – Counting Religious Purpose as a Tax-Exemption Factor for Hospitals," *Seton Hall Law Review* 42, no. 1549 (2012): 1555.

community hospitals in the United States in 2009 were Catholic hospitals.[57] Of the forty largest hospital systems in the country, eleven were Catholic hospitals and facilities, making them the nation's leading non-profit healthcare system.[58]

Within the Methodist tradition, the United Methodist Church leads the way in its facilitation of healthcare institutions. Affiliates in twenty-one states provide services ranging from large, acute care hospitals, emergency centers and cancer treatment centers to assisted and independent living centers, hospices, substance abuse treatment and education centers, schools of nursing, home health services, and outpatient clinics.[59]

Other denominations of the Wesleyan Tradition have largely remained out of the healthcare business as proprietors of hospitals and hospital organizations. Instead, they use their meeting spaces to provide child and elder care, hold Alcoholics Anonymous and Narcotics Anonymous meetings, and to provide other counseling services. While some do support various clinics, many continue in the missionary journey of providing food, clothing, and visitation to the needy.

AME Church Role in Health Ministries

The African Methodist Episcopal Church has a healthcare platform that extends from its leadership at the Connectional level, down through the Episcopal Districts, Conferences, Presiding Elders and to the local churches. The bishops of the AME Church

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[57] DeBoer, "Religious Hospitals," 1556.

[58] DeBoer, "Religious Hospitals," 1557.

[59] United Methodist Church Directory: Hospitals, accessed February 15, 2017, http:// www. umc. org/ directory/hospitals.

set the tone as advocates for health and wellness, strong communities and civil rights within their individual bishoprics and across the Connection as a whole.

The AME Health Commission is a member commission of the Church's General Board.[60] This commission reaches out across the Connection to encourage congregants to lead healthier lives. From text messaging health information to providing print and electronic resources such as information on heart and prostate health, the AME Health Commission promotes healthy lifestyles, increased activity and caring for our fellowman.[61] Each church and organization within the connection continue to mobilize to fulfill the AME Church's vision "to seek out and save the lost, and to serve the needy."[62]

Aside from the Connectional focus, AME ministers and churches assist in creating healthier congregations through participation in research activities. Large research projects such as the Health-e-AME initiative,[63] the Faith, Activity, and Nutrition (FAN) Program,[64] research on physical activity,[65] have been supported by national grants. Although many projects were conducted in individual churches, some such as the

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[60] AME Church Mission, accessed February 28, 2013, http://www.ame-church.com/our-church/our-mission/.

[61] AME Church Health Commission, accessed February 2, 2017, http://amechealth.org/ cate gory/amechealth.

[62] AME Church Mission, accessed February 28, 2013, http://www.ame-church.com/our-church/our-mission/.

[63] Sara Wilcox, Marilyn Laken, Thaje Anderson, Melissa Bopp, Deborah Bryant, Rickey Carter, Octavia Gethers et al. "The Health-e-AME Faith-Based Physical Activity Initiative: Description and Baseline Findings," *Health Promotion Practice* 8, no.1 (2007): 69-78.

[64] Sara Wilcox, Marilyn Laken, Allen W. Parrott, Margaret Condrasky, Ruth Saunders, Cheryl L. Addy, Rebecca Evans, Meghan Baruth, and May Samuel, "The Faith, Activity, And Nutrition (FAN) Program: Design of A Participatory Research Intervention to Increase Physical Activity and Improve Dietary Habits in African American Churches," *Contemporary Clinical Trials* 31, no. 4 (2010): 323-335.

[65] Melissa Bopp, Sara Wilcox, Marilyn Laken, Kimberly Butler, Rickey E. Carter, Lottie McClorin, and Antronette Yancey, "Factors Associated with Physical Activity Among African-American Men and Women," *American Journal of Preventive Medicine* 30, no. 4 (2006): 340-346.

"Provider Health Advice" project focused on churches across an entire Episcopal District.[66] Research such as the "HIV among Black Men in New York" project[67] has also been conducted in conjunction with other denominations.

Beyond a Footnote: The AME Church's Role in the Yellow Fever Epidemic

The Free African Society (FAS) was established by Richard Allen and Absalom Jones in 1787.[68] The Society was one of the first so-called, mutual aid societies in Philadelphia and became a template for other mutual aid societies across the northeast. The FAS served the African population in Philadelphia by providing a place for its members to receive social help and assistance and meet their religious needs as well. The Free African Society also provided nursing and medical care to its members. Of historic note is the untiring efforts of Rev. Allen and the Society to help the citizens of Philadelphia during the yellow fever outbreak of 1793. Members of the Society were asked to "come forward and assist the distressed, perishing, and neglected sick" on the unfounded claim that they could not contract the yellow fever virus.[69] Rev. Allen and the FAS tended the sick, secured nurses, removed the deceased from their beds.[70] Later,

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[66] Elizabeth A. Fallon, Sara Wilcox, and Marilyn Laken. "Health Care Provider Advice for African American Adults Not Meeting Health Behavior Recommendations," *Preventing Chronic Disease* 3, no. 2 (2006): A45.

[67] Patrick A. Wilson, Natalie M. Wittlin, Miguel Munoz-Laboy, and Richard Parker, "Ideologies of Black Churches in New York City and the Public Health Crisis of HIV Among Black Men Who Have Sex with Men," *Global Public Health* 6, no. sup2 (2011): S227-S242.

[68] Lincoln and Mamiya, 51.

[69] Richard Allen, 29.

[70] Richard Allen, 29-31.

under the direction of Dr. Benjamin Rush, they also obtained and administered medications and bled patients as ordered.[71] Although they were paid the scant amount of nearly three hundred pounds for their troubles, Allen and his members had a net loss that was too numerous to be counted. Included in the losses were the cost of making coffins, burying the dead, paying helpers, hiring hearses, caring for the families of the helpers, and many other associated duties.[72] Despite their altruism, Allen had to appeal to the mayor of Philadelphia to uphold their good name against accusations made by publisher Matthew Carey that they had taken advantage of the city's citizens.[73]

Conclusion

In this document, we discussed the context of the author as being from the Savannah South District. Her goal is to teach healthy lifestyle behaviors within her context. The concepts of medicine, health, and wellness were discussed as well. Health, defined as the state of complete physical, mental, and social well-being by the World Health Organization, is elusive for many Americans, especially African Americans. Wellness goes hand in hand with health.

In order to provide a clearer understanding of the context of the Methodist or Wesleyan tradition in America, the history of Methodism was briefly discussed. John Wesley's Oxford years led to his voyage as a missionary to the New World. This newfound religion was quick to take hold in America which was still a developing

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[71] Richard Allen, 29-30.

[72] Richard Allen, 31-44.

[73] Richard Allen, 29-45.

country. The itinerancy and the circuit riders fit well into the novel American culture, becoming, over time, the Methodist Episcopal Church. Many denominations trace their beginnings to the Methodist Episcopal Church, including the United Methodist Church and the African Methodist Episcopal Church.

John Wesley also led the way for pastors to teach and preach health and wholeness to their congregations. He believed that God expected pastors to care for the whole person and personally cared for the sick his whole life. Wesley also wrote massively on health and wellness. He published many books and leaflets including the famous *Primitive Physick.*

Health care in early America was centered in the homes of the sick. Early health institutions included almshouses and mental wards. It was not until the late 1700s that the first hospitals for in-patient care were built in America. Early hospitals were built to keep the infectious, poor, elderly, homeless, abandoned, or otherwise disenfranchised citizens away from the rest of society. Religious outreach from both Catholic and Protestant denominations began within these facilities. Hospital growth was spurred on because of the poor condition of these hospitals and the suffering of their patients. The Civil war also helped launched the growth of hospitals and other medical advances.

Just as it has been for the rest of the country, health and wellness in the Methodist Tradition has continued to evolve. The Church has played and continues to play a variety of roles to ensure the health of its congregants and communities worldwide. From clinics to hospitals, counseling to elder care, support missions and research, denominations of the Wesleyan tradition continue to provide healthcare centered on physical health and wholeness. Today in many quarters of each state, churches continue to play a role in

health care by putting on health fairs. Much of this is done without grant money from various quarters. Numbered among the volunteers at these health fairs are doctors, nurses and other health care workers. This foundational unit, along with others, is a prelude to the health-related project that I will endeavor in this doctoral journey.

CHAPTER FOUR

THEOLOGICAL FOUNDATIONS

Introduction

The project that I have chosen, to which my foundational works articulate, is one that deals with cardiovascular health. This endeavor is targeted to the ministers and congregations of the Savannah South District of the African Methodist Episcopal Church of which I am a part. Cardiovascular disease is something that affects every member of the human race. This disease is a predominant source of death and disability in the United States and is more prevalent in the southern states. When cardiovascular disease is discussed in the health science field, several diseases/ailments are viewed. Prevalent among them are heart diseases, heart failure, heart attacks, strokes, and death.

It is of interest to note that much of the organic health food phenomenon is rooted in the understanding that certain types of produce, vegetables, dairy and meats are healthier in that these foods are better absorbed by the body and the nutritional value is greater than produce and meats that involve a higher concentration of fertilizer and antibiotics that produce more toxins which in turns plays a significant role in diseases of the body. For many, a conscious choice of selecting foods is rooted in better health; at the same time, for many this life style choice is rooted in a faith conscious.

The premise of this work is that teaching healthy lifestyles is paramount to discipleship for many reasons. It helps ward off certain diseases and ailments and grants a

greater degree of mobility. Also, it must be underscored that discipleship includes not only how we treat neighbors and strangers but also ourselves. The body is understood in Christian teaching (theology) as the temple which is not to be defiled. Hence, it is important for clergy and the lay leadership alike to preach and teach on various themes in scripture that underscore healthy life styles. It is also important for church leadership and denominational general offices, where there is such, to develop a theology of health and wellbeing. There are many and significant texts in both the Old and New Testaments to highlight sermon series and bible studies on this subject. It is also important for developing a theological blueprint or imprint on what is meant by healthy lifestyles, what are the challenges and how does one both articulate this and put in into practice. This theological foundation will examine several theologies and view how they speak to healthy lifestyle changes. Among these theologies are practical theology, liberation/black theology, soteriology, and pastoral theology.

Practical Theology

The subject of practical theology is an understanding and construct of theology in a context beyond elaborating on the basic character and nature of God. Practical theology came into existence in the late eighteenth century within German academics. The purpose of practical theology was to apply theological principles to church activities such as church worship, preaching, teaching and government.[1]

> Friedrich Schleiermacher, C. I. Nitzch and Philip Marheineke began the connection between Christian theology and the social sciences. Schleiermacher is

[1] Tim Sensing, "A Brief Historical Overview of Practical Theology," accessed October 31, 2016, http://www.thekingpin68blogspot.com/2013/01/a-brief-historical -overview-of.html.

> likely the first to work with such concepts. What developed from these understandings was the notion that theoretical theology that deals with possibilities between life and action needs to be differentiated from practical theology that deals with realities between life and action.[2]

Hence, practical theology is a theology that deals with life and action in the context of that which is carried out in a practical manner as opposed to delving into theoretical thoughts and abstracts. "The subdiscipline of practical theology was established as a discipline of church practice, contrasted with three theoretical disciplines – biblical, systematic, and historical theology."[3]

Practical Theology and Preaching

More than any other aspect of church life, more people are – on average – in a service of worship more than bible study, prayer meetings, administrative meetings, or Sunday school. That is to say that more people sit at the feet of the preacher who is charged with delivering God's word. Much of this preaching is done haphazardly, or so it seems. Many preachers, if not most, do not have a system of developing sermon topics less more a homiletical design. In addition to preaching to and about social issues which is prevalent in many African American pulpits, preachers would do well to consider the lifestyles that contribute to many illnesses and disease. Hence, the preacher, in her context of being a practicing theoretician and theologian, can bring to light the role of

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[2] Sensing, "A Brief Historical Overview of Practical Theology."

[3] R. Ruard Ganzevoort, *Hermeneutics and Empirical Research in Practical Theology,* eds. Chris A. M. Hermans and Mary E. Moore. Leiden: Brill 2004, 53-74, accessed October 31, 2016, www.brill.com.

discipleship in faith in the context of healthy lifestyles. Practical theology has much to say to preachers about sermon content in this regard.

> Biblical studies and systematic theology have assumed the sole right to ask basic questions about sermon content, with the only concern of practical theology being the preacher's delivery system (i.e., the technique) used in preaching and in other aspects of gospel ministry. Thus, practical theology has had the task of equipping people with the skills needed for a successful ministry, the adjective "practical" indicating the application of theology.[4]

This application of theology calls for the preacher to equip the people with the biblical foundation for the care of the body as found in both the Old and New Testament teachings but also how does one go about this beyond the age-old response of "self-will." G. Van Wyk, is his work "From Applied Theology to Practical Theology," writes:

> The minister prepares a sermon about the atonement, a topic which is accepted a priori as relevant for the congregation. But he observes, to his amazement, that no one is really listening. Why not? Did he fail to provide enough striking illustrations? Did he lack enthusiasm? Did he stumble in his delivery? Perhaps so. But it is equally or even more likely that he was not addressing or connecting this message with the congregation's *Sitz im Leben*, the specific and total life situation of the listeners. Persons listening to a sermon are not merely a receiving set; their own situation contributes to the preaching event. That event is, in its very nature, a dynamic encounter between people and the Word of God. [5]

In this encounter between the setting in life, *sitz im leben,* the preacher can bring to bear the outside external influences of advertising, fast food appeal, working parents and quick meals and paint a picture about how more and more Americans have increase their weight significantly over the past forty years. The setting in life also can point to more sedentary lifestyles as well and how this has contributed to weight gain. For sure, there is a genetic component in weight gain. This cannot be overlooked entirely, yet the preacher

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[4] G. Van Wyk, "From 'Applied Theology' to 'Practical Theology,'" Andrews University Seminary Studies, Spring 1995, Vol. 33, no. 1, 85-100, accessed November 3, 2016, https:/.mail.google.com/mail/u/0/?shva= 1#inbox/ 1581d2370ca63?projector=1.

[5] Wyk, "From 'Applied Theology' to 'Practical Theology.'"

has a unique opportunity to address this subject in his/her teaching and preaching. The African American preachers can learn from many white ministers who use video projectors in their sermons. This feature can show clips about diet, exercise, health care and more to assist in the message. The visual aids can go a long way in being effective in communicating God's word.

Denominational Health Ministries

Most pastors in America are bi-vocational. Many of these pastors travel great distance to their churches as well. Some of these pastors have little or no education beyond high school and do not know where to turn for help in learning about resources for themselves and their churches. One good resource can be found in the work of the denomination's office. Some smaller denominations do not have this, but some of the larger ones do. The African Methodist Episcopal Church denomination has major offices. The Health Commission addresses health care and wholeness.[6] The United Methodist Church does have such an office that provides literature, study guides and other resources to assist pastors as they seek to teach and inform their congregations.

> The United Methodist Church some years ago also instituted a nationwide Health Ministry Network (managed through the General Board of Pensions) and has established wellness programs to assist clergy in their health questions and practices. However, as all of these initiatives point out, clergy first need to have a self-awareness and a desire to live a healthy lifestyle. And lifestyle is about practices and disciplines that lead to healthy living."[7]

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[6] The Health Commission of the African Methodist Episcopal Church, accessed April 14, 2016, http://www.amechealth.org/.

[7] Todd Outcalt, "Five Fit Practices for Clergy," Media Matters, April 14, 2016, accessed November 7, 2016, htpp://www.ministrymatters.com/allentry/6850/five-fit-practices-for-clergy.

Leading – as well as teaching – comes about through example. The minister that makes this conversation about healthy life-style choices a part of her ongoing conversation can maximize the preaching on this subject in that she has led from example. This is practical theology lived out in praxis (practice). The poem by Edgar A. Guest speaks of a person "would rather see a sermon than to hear one."[8]

A ministry of observing best practices by ministers can aid them in their overall program ministry and preaching. For sure, many pastors have limitations in resources and time, yet they can learn much from others with best practices in this regard. Rev. Dr. Jeff Wilson, a minister at Brentwood United Methodist Church (BUMC) in Brentwood, Tennessee, has much to offer by way of practical theology as it relates to ministry and preaching. He said, "As churches, we noticed that there were a lot of older folk in our congregations, but just because we gear up to attract and serve a younger crowd doesn't mean we ignore the old one."[9] Under his leadership Brentwood UMC created an "older adult" ministry. He said, "It was kind of a quiet roll-out. We didn't need a logo or a catchy tagline to create awareness: our target audience was already here."[10] This church holds quarterly events that highlight concerns among older adults including physical health, mental health and spirituality.[11]

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[8] Edgar Guest, "I'd Rather See A Sermon," accessed November 28, 2016, http://www.inspirationpeak.com.

[9] Judy Bumgarner, "Staying Focused on Older Adults," Media Matters, accessed November 28, 2016, http://www.ministrymatters.com/lead/entry/7770/staying-focused-on-older-adults.

[10] Bumgarner, "Staying Focused on Older Adults."

[11] Bumgarner, "Staying Focused on Older Adults."

Practical Theology and Healthy Life Styles

The church must come to grips with the health care epidemic of obesity and its causes and put it in the context of sickness. Every week ministers call the faithful to lead lives of discipleship and all that it entails. The gospel is preached and the people are reminded that the body is the "temple of Holy Spirit" (I Cor 6:19-20). Many ministers also preach from the gospel narratives where Jesus heals the sick and afflicted. The faithful are reminded that Jesus is described as the "Great Physician" who is still able to heal. Prayers are punctuated with the rejoinder that "there is still a balm in Gilead" which speaks of the concern of God for the sick. Yet, obesity and unhealthy lifestyles are rarely mentioned if mentioned at all. Many church dinners – anniversaries, homecoming celebrations, and funerals repast meals– are served with food that are high in calories and cholesterol. Ministers must become servants of the church that are steeped in theological reflections that will lead them to address the subject of unhealthy eating habits and sedentary life styles. William E. Hulme, in his article "The Cure of the Soul," writes,

> The power for healing the sick soul is in the good news of God's agape – the redemption from sin and death effected by the life, death, and resurrection of Christ as this is made real to us by the Holy Spirit. It is significant that Jesus' ministry was a healing ministry for the body as well as for the soul. Always, however, it was a healing at the level of the God-man relationship. Reconciliation in this relationship is the source of the faith that makes men whole. It is this healing ministry of Christ which the Church through the power of his Holy Spirit carries forth.[12]

Interestingly, the term doctor, in a symbolic sense, has been given to the preacher who see himself/herself as one who is an examiner of the human condition of sin and knows

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[12] William E. Hulme, "The Cure of the Soul," in *Theology in the Life of the Church*, ed. Robert W. Bertram (Philadelphia, PA: Fortress Press, 1963), 106-107.

how to treat it with the gospel. This application should be operative in the life of the preacher as far as health is concern as well. In this context, the minister is a different kind of diagnostician.

> The preacher must as a medical diagnostician see the pain, hurt and guilt of many Christians who suffer silently about issues of weight and immobility. In addition to being ostracized by society, media and popular culture, they [people] spend days in what Ralph Waldo Emmerson calls 'quiet desperation.' The preacher in this diagnostic context has a word from God about grace.[13]

This work of the preacher is of importance not only in being a diagnostician for overweight women and men in their middle years but also discerning the heartaches and hardship of the young.

> Of major concern during development is the adolescent's search for identity and a strengthening of his or her self-image. Merton Strommen, in his book *Five Cries of Youth*, states that almost three-fourths of all young people are struggling with low self-esteem at one time or another. The problems with their skin, hair, teeth, voice and weight don't help the self-image situation either. Developing a value system is of prime importance to the adolescent because that will be the guideline for living and functioning in the world. Parents, ministers and other Christian adults make contributions and influence this system, but so does the peer group.[14]

Hence, the preacher-theologian-diagnostician must have an understanding of not only the scripture but also an understanding of theology in how it frames the preacher's teaching, preaching, counselling and church development of church ministries. This same gospel speaks to all of the needs of people.

> In what Jesus says about God's goodness, the creative and sustaining work of the Father is at the heart. But closely related is his saving and forgiving activity as an expression of his mercy (Matt. 18:33; cf. Luke 10:37). God's merciful turning to the need, the suffering, and the helpless must thus be seen as a specific expression of his goodness and its practice, not a different quality. In this light we can see

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[13] Wolfhart Pannenberg, *Systematic Theology*, vol. 1, trans. Geoffrey W. Bromiley (Grand Rapids, MI: Eerdmans Publishing Co., 1991), 432-433.

[14] James L. Milton, "Adolescence: Stuck in the Middle," in *Caring for People from Birth to Death*, ed. James E. Hightower (New York, NY: The Hatworth Press, 1999), 46-47.

> why Paul could make the grace of God (charis) the central expression of his goodness (Rom. 3:24; 4:16).[15]

Grace should be expressed as abounding in every aspect of the life of people of faith. It should not just be restricted as a salve to those who are grievous because of their sinful nature and deeds; it must also be directed as those who are grievous because of their struggle with weight gain, sedentary life styles and those persons whose physical features that do not match the cultural standards of beauty as dictated by Hollywood and commercial advertisement.

Physical illness, which includes obesity and all the health challenges that come with it, plays a role in the psyche of an individual as well as one's faith in that one struggles to see oneself in the image of God as well as one seeing oneself as being all that God wants them to be. Cornelius J. van der Poel sheds light on physical illness against the backdrop of "wholeness and holiness." He writes,

> Health care ministry is a special focus on the understanding of ministry, which includes in a particular way, the concern for human wholeness and integration at times of illness. It includes the physical as well as the emotional and spiritual well-being of the patients. Health care ministry focuses on the total person. Because of the inseparable unity of the material, emotional, and spiritual dimensions of human existence, the concern for physical wholeness has a direct bearing on the from in which an individual will respond to other persons and to God. Material qualities of life strongly influence the psychological and spiritual dimensions of each person. Thus ministry, especially health care ministry, is not an addition to or an imposition upon human relationships. It belongs to the human reality. It is a perspective of human life and an expression of religious values. It is therefore a mandate for the Church or for the Christian community.[16]

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[15] Pannenberg, *Systematic Theology*, 432-433.

[16] Cornelius J. van der Poel, *Wholeness and Holiness: A Christian Response to Human Suffering* (Franklin, WI: Sheed & Ward, 1999), 12-13.

Life is an integration of the physical, spiritual and social components. The church cannot continue to operate in a sphere that physical wellbeing is detached from our spiritual lives. Preaching must connect all aspects of human existence, even the unpleasant aspect of challenging people about their eating and physical activity habits as well as their behavior in the realm of mistreatment of others and breaking of God's laws. This has to be driven by theology.

> It is rather common attitude to consider health and perfection as blessings while illness is understood as a curse unworthy of human existence. The progress of medical science and technology makes it very difficult for the present generation to accept illness and suffering as basic human realities and to understand the ability to suffer as a fundamental prerequisite for the appreciation of health.[17]

Theological reflections on the sickness and suffering have to be tied into a larger discussion of lifestyle choices, genetic markers, economic-social factors as well as the role of grace and the activity of the Holy Spirit in addressing health concerns.

Liberation/Black Theology and Health

Numbered among the offspring of liberation theology is black theology. When the subject of black theology is discussed, attention is often centered on measures of oppression that the dark-skinned sons and daughters of African slaves endure in America. One of the earliest theologians to articulate black theology was James Cone. In his book, *Liberation,* published in 1970, Cone identifies the content of black theology. Cone writes,

> Christian theology is a theology of liberation. It is a rational study of the being of God in the world in light of the existential situation of an oppressed community, relating the forces of liberation to the essence of the gospel, which is Jesus Christ. This means that its sole reason for existence is to put into ordered speech the meaning of God's activity in the world, so that the community of oppressed will

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[17] van der Poel, *Wholeness and Holiness,* 40.

> recognize that their inner thrust for liberation is not only consistent with the gospel but is the gospel of Jesus Christ.[18]

In this book, Cone speaks of the existential situation of black people in America with state-sponsored (or indifference to) oppression with all the horrors that this entails. Cone continues,

> Insofar as Black Theology is a theology arising from and identification with the oppressed black community and seeks to interpret the gospel of Jesus Christ in the light of the liberation of that community, it is Christian theology. American white theology is a theology of the Antichrist, insofar as it arises from an identification with the white community, thereby placing God's approval on white oppression of black existence.[19]

Cone makes the argument against those who trumpet the authenticity of classical theology while devaluing black theology at best and declaring it an aberration of (pure) classical theology at worse. What should not be loss in such definitions as it relates to theology is God's response to the suffering nature of a people. Was this not at the center of the liberation of the Hebrews in Egypt? While bondage of slavery is certainly a central component of oppression, there are other measures of oppression that include access to health care and the quality of that health care.

Some of the measures of oppression limits people to where they can work and live which have economic implications. One implication is health care. Poor people, on average, have more challenges getting health care period – not to mention the quality of such care. The fallout and main reasons for obesity cannot be limited exclusively to poor eating habits of individuals and a lack of discipline in exercising. (This goes into the realm of the theoretical foundations which will be explored in another section). However,

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[18] James Cone, *Liberation* (Philadelphia, PA: J. B. Lippincott Company, 1970), 17.

[19] Cone, *Liberation*, 25.

there are theological implications for the challenges that people face. Black theology speaks to these challenges in that it addresses the institutions that keep people in enclaves of systems where the choices that they have are limited because of oppressive systems.

Cone's articulation of black power is juxtaposed with Christianity – which is to say white theology – in how the gospel is portrayed that ignores systems of racism and oppression that not only stifle but also contribute to the quality of life for black people in America as well as other people who are marginalized. Cone cites Maulana Karenga in his critique of white Christianity, i.e. white theology,

> We must concern ourselves with this life which has its own problems. For the next life across Jordan is much further away from the growl of dogs and policeman and the pains of hunger and disease.[20]

These words were penned almost fifty years ago. Things have improved in that blacks do not face "the growl of dogs," but they do face the issues of hunger and disease. Hence, the message from the pulpit cannot be hit and miss about "hunger, malnutrition and disease." It must be couched in a theological framework that goes beyond mission work of feeding the hungry even though this is an imperative of the prophetic message of Jesus Christ. This theological framework must also address how the gospel speaks to those oppressive forces that marginalize poor people in how they overcome the challenges of Christ in areas of nutrition, exercise and access to affordable and quality health care.

Many poor people are forced to make choices of foods that are high in fat and sugar because of their income level and accessibility to markets where more fresh fruits

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[20] Vincent Harding, "The Religion of Black Power," in *The Religious Situation*, ed. D. R. Cutler (Boston, MA: Beacon Press, 1968), 8. in James H. Cone, *Black Theology & Black Power* (New York, NY: Seabury Press, 1969), 33.

and vegetables are sold and are more expensive. These concerns lie in the context of liberation theology where black theology is housed.

> An effective and plausible black practical theology of health and health care must be driven by a ceaseless quest to understand the world. This understanding is not, however, merely of the world as it ought or could be, or of the world as imagined through a set of moral practices that exhort Christians to take flight from their present reality; rather, it is an understanding of the world as it actually is. For millions of blacks, the world as it actually is consists of widespread injustice, poverty, marginalization, pain, and suffering.[21]

Oppression and injustice leave in its wake a multitude of ills, many of which are health related. Disease, a higher than expected mortality rate and a lower standard of overall health is the makeup of many left in this wake. "In January 2011, the Centers for Disease Control and Prevention (CDC) published its CDC Health Disparities and Inequalities Report, which defines health disparities 'differences in health outcomes between groups that reflect social injustices.'"[22]

> a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion.[23]

What does all of this have to do with theology? This has everything to do with theology in that we understand the character of God to be that of love. We understand the body to be the temple of God and must not be defiled. Hence, liberation (black) theology goes up

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[21] Edward P. Antonio, "Black Practical Theology of Health and HIV/AIDS Health Care," in *Black Practical Theology*, eds. Dale P. Andrews and Robert London Smith (Waco, TX; Baylor University Press, 2013), 220.

[22] Antonio, "Black Practical Theology of Health and HIV/AIDS Health Care," 219.

[23] Antonio, "Black Practical Theology of Health and HIV/AIDS Health Care," 219.

against systems that not only oppress the physical element of people being forced into a life style of limitation physically but also bodies being overwhelmed with challenges of food choices and health care.

> Black and womanist theologies, as well as African American churches, have been not only aware of this desperate situation but also shaped by it. Black and womanist theologies claim to be theologies of liberation. These struggles call for empowerment and capacity building in the struggle for a more just health-care system . . . black and womanist practical theologies must seek to make effective emancipative interventions in this social order.[24]

This effort will not come alone through the preaching of the gospel but through a theological construct of local congregation, ministers conferences, lay councils, ministerial alliances as well as theological discourse and collaborative efforts of the seminary and the church.

According to black theology, then, we are to be concerned about our bodies, We believe in the sanctity of the soma (body). The body is worthful in its own right because it is a part of God's creation. The fleshly life of man was in God's creative purpose when he declared it "good" and is his re-creative purpose when the Word became flesh. "Just as the Hebrews viewed man as a whole, body and soul, even so our African forefathers affirmed the unity and wholeness of life."[25] The construct of liberation/black theology offers much to the discussion of healthy lifestyles, particular in some of barrier to this. J. Deotis Roberts poignantly addresses this concern. Roberts asserts,

> man is political in black theology. John Mbiti, in outlining the hierarchical scheme of religion in African societies, offers this description: First comes the healer, then the prophet, then the evangelist and finally the baptizer. The tragedy

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[24] Antonio, "Black Practical Theology of Health and HIV/AIDS Health Care," 220-221.

[25] J. Deotis Roberts, *A Black Political Theology* (Philadelphia, PA: Westminster Press, 1974), 92.

> of American Christianity is that we desire only to evangelize and baptize. We omit too often the healing and the prophetic imperatives of our faith.[26]

In revisiting the work of Mbiti, Roberts presents a theological paradigm construct that has much to offer the Christian minister and church. Christian theology must learn to speak about the God of Jesus of Nazareth who preferentially identifies with and walks with the poor, excluded and despised."[27] In the current context of widespread and persistent global poverty, injustice, and exploitation, Christian theology, in its effort to incarnate integrity and authenticity, can no longer ignore the cry of the poor, excluded and despised for life.[28]

Womanist Theology

Another tenant in the house of liberation theology is womanist theology. It too speaks to the subject of health. Dr. Jacquelyn Grant defines womanist theology as

> a theological perspective that emerges out of the experiences of Black women. These experiences include not only Black women's activities in the larger society, but also in the churches. I emphasize the fact that Black women have often rejected oppressive structures in the church and larger society. These experiences provide a context conducive to doing theology. They have been and continue to be defined by racism, sexism and classism and, therefore, offer a unique opportunity and a new challenge for developing a relevant perspective in theology. Womanist theology draws from the life experiences of some Black women who have contributed meaningful interpretations of the Christian faith.[29]

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[26] Roberts, *A Black Political Theology,* 93.

[27] M. Shawn Copeland, "Poor is the Color of God," in *The Option for the Poor In Christian Theology*, ed. Daniel G. Gregory (Notre Dame, IN: University of Notre Dame Press, 217.

[28] Copeland, "Poor is the Color of God," 216.

[29] Jacquelyn Grant, "Womanist Theology in North America," *Journal of the Interdenominational Theological Seminary* (September 1, 1988): 285.

I guess it could be argued that since women outnumber men in population, there are more women who are overweight than men in society. There are certainly more women than men in church attendance. Women who are already facing health challenges because of weight are also judged by men (and society) differently than from men. Hence, women face elements of sexism and ostracism – some of which is rooted in their health challenges. Womanist theology speaks to all aspects of women's existential existence, including the church and health. Delores Williams speaks to the overall challenges that women face in society (including the church) in her theological construct of the development of "survival/positive quality of life" and "resistance strategies" as found in her book *Sisters in the Wilderness: The Challenge of Womanist God-Talk*.[30] In this context, women will need to work out their own construct for esteem and self-care while challenging the power structure even in the church. Claudia Highbaugh adds to this discussion.

> Our churches are preaching, teaching the work, singing, praying and lighting up the media with high and holy spirit. It is essential, that as women scholars and women practicing scholarship, community health, and wholeness, we seek the sacred and holy ground of transformation that pushes, shouts, and work out solutions that heal us and discontinue the practice of secret keeping.[31]

It is essential that while liberation theology has attached to it wholeness as it relates to salvation and good health, women (and men) must realize that women have some unique circumstances that it faces in society in general; this is sometime even more pronounced for women of color.

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[30] Delores S. Williams, *Sisters in the Wilderness: The Challenge of Womanist God-Talk* (Maryknoll, NY: Orbis Books, 1993), 10-11.

[31] Claudia Highbaugh, "Transformation of Consciousness: Taking it to the Pews," *Union Seminary Quarterly Review* (January 1, 2014): 184-185.

Soteriology and Health

It must not be lost on believers that "wholeness," which includes health, was of primary importance of Jesus. "He [Jesus] also chooses and sends out the twelve apostles and the seventy (Lk 10:1) and gives them power and authority to act in his name in peaching, teaching and healing (Mt. 10:40).[32] The concept of salvation, from the Acts of the Apostles and the epistles in New Testament, deals with salvation from the perspective "God himself who is providing for sinners the means of forgiveness and therefore of fellowship with himself; it was God who reconcile us to himself through Christ who reconciled God to us." [33]All of this stems from Jesus suffering and dying on the cross thus relieving sinners from the penalty of death for those who believe, are baptized and follow in his ways. The Old Testament, however, has a broader understanding of salvation that speaks of deliverance, safety and wholeness. These Old Testament seeds of salvation form part of the bedrock of faith that one's existence is rooted in faith in Christ through this salvific history of God as deliverer and Christ as redeemer. The concern about health and welfare are not inconsistent with concerns that Christians should have. To be saved means more than being "fitted for the sky" after death. It involves the trust in God's faithfulness to meet the needs of the believer on earth.

> The Christian view of salvation must move, in what may seem a scandalous manner, away from general truths about the nature of existence to a very particular moment with Salvation, or the healing of life, issues from atonement, and this in turn has its basis in the crucifixion of Christ. All roads lead, not to Rome, but to a mound of earth outside the walls of a Middle Eastern town in a remote corner of the Roman Empire. For Some theologians, that particular event expresses and reveals in the clearest possible way the self-giving, reconciling love of God which is always available. If salvation is a continuous process, then it

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[32] Owen C. Thomas, *Introduction To Theology* (Wilton, CT: Morehouse-Barlow, Inc., 1983), 271.

[33] Alan Richardson, "Salvation," in *The Interpreter's Dictionary of the Bible*, Vol 4, R-Z, ed. George Arthur Buttrick (Nashville, TN: Abingdon Press, 1962), 179-180.

> happens here and now. It is in the present that God acts to heal and reconcile, entering at great cost into the disruption of human lives, in order to share our predicament and release us from it.[34]

This theological construct helps the believer to understand that God's salvation is not confined to the believer in the afterlife only but is operative in the "here and now."

Pastoral Theology

When the subject of pastoral theology is addressed, some theologians believe that it should be housed in the theological loci of practical theology under counselling while others believe that pastoral theology is a distinct branch of theology. Alastair Campbell posits, "Notions of pastoral theology and practical theology are often confused, used differently, or used synonymously."[35] While some measures of theological discourse can easily be assigned to a certain theological school, much discourse cannot be neatly housed in a specific theological school. John Howard Yoder expressed this thought when he posited, "There is no longer any evident right answer to theological questions."[36] By way of definition, Karl Rahner defines pastoral theology as "that theological discipline which is concerned with the Church's self-actualisation here and now – both that which is and what which ought to be."[37] Though this quote is expressed awkwardly, it nonetheless

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[34] Paul S. Fiddes, "Salvation," in *The Oxford Handbook of Systematic Theology*, eds. John Webster, Kathryn Tanner and Iain Torrance (New Your, NY: Oxford University Press, 2007), 178.

[35] Alastair Campbell, "The Name of Practical Theology," in *the Blackwell Reader in Pastoral and Practical Theology*, eds. James Woodward, Stephen Pattison, and John Patton (Oxford, UK: Malden, MS: Blackwell Publishers, 2000), 75.

[36] John Howard Yoder, *Preface to Theology: Christology and Theological Method* (Grand Rapids, MI: Brazos, 2002), 233.

[37] Karl Rahner, "Practical Theology Within the Totality of Theological Disciplines," in *Theological Investigations 9* (Baltimore, MD: Helicon Press, 2009), 102.

has in it a component that is both what is known in church parlance an "earthly and heavenly" sphere. In the earthly sphere, many of the faithful, as well as those who are outside of the Christian faith, have issues of health-related disease of obesity and malnutrition as well as a lifestyle of physical inactivity. The gospel message through theological discourse must speak to this as well.

Most churches in the black tradition, Baptist and other denominations, are served by ministers who do not have seminary trained ministers. Many of these ministers do not know the nuances of an articulated theological discourse nor theories of counselling. Yet, these ministers have offered much to their parishioners in their existential situation in what is called *soul theology* (the telling of stories). The telling of stories has as a part of its components a function to bring healing and wholeness to the lives of persons and families within the black pastoral care context. Henry Mitchell and Nicholas Lewter call such stories *soul theology*, the core belief-system that gives shape to the world, that shows how African American people have come to grips with the world in a meaningful way.[38] Part of this coming to grips involves issues of health challenges that manifest themselves in cardiovascular disease and a host of other ailments. Also, included in this coming to grips is low self-esteem and all that this entails. In the pews every Sunday, as well as those who are absent, are persons who are beset with both physical and psychological issues. They are wounded. It is through the efforts of pastoral theology that is wedded to other theological thoughts that can offer a word of hope and give directions to the challenges that people face.

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[38] Henry Mitchell and Nicholas Lewter, *Soul Theology* (New York, NY: Harper & Row, 1986), 11.

Dr. Edward P. Wimberly, a United Methodist minister and professor of pastoral care at the Interdenominational Theological Center, has written extensively on the subject of pastoral care and how it has been developed in the black church tradition. He also expounds on the *soul theology* motif. Wimberly contends that much of pastoral counselling takes place in morning worship through preaching and music. The stories of faith are shared in both a "story-telling" and "story-listening" context where the worshipper are brought into the dialogue and the existential situation of the biblical text parallels his or her own life.

> These narratives suggest ways to motivate people to action, help them to see themselves in a new light, help them recognize new resources, enable them to channel behavior in constructive ways, sustain them in crises, bring healing and reconciliation in relationships, heal the scars of memories, and provide guidance when direction is needed. Soul theology makes up the faith story that undergirds the stories used by black pastors and parishioners in caring for others. And how that faith story has brought healing and wholeness through storytelling.[39]

Wimberly asserts that pastoral care is extremely important in worship through preaching with its story telling that speaks poignantly to people. He posits that *soul theology* and storytelling do not end it worship. He continues,

> Pastoral care, on the other hand, uses storytelling in the context of caring relationships, to help remove the personal and interpersonal obstacles that can hinder people's ability to grow. The goal of pastoral care and counseling, from a narrative perspective, is to use storytelling to strengthen people's personal and interpersonal growth, so that they can respond to God's salvation drama as it unfolds and impacts their lives.[40]

This work of pastoral care takes place in small group meetings as well as through individual and/or family counselling. In pastoral theology, the process of reflection

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[39] Edward P. Wimberly, *African American Pastoral Care* (Nashville, TN: Abingdon Press, 1991), 12.

[40] Wimberly, *African American Pastoral Care*, 17-18.

begins in a particular situation where personal suffering or anxiety surfaces. The first act in pastoral theology is thus "naming" the problem.[41] We know that some of the problems are health care (weight and the self-esteem associated with it) and other accompanying illnesses. Thus, pastoral theology speaks to health not just in a psycho and socio manner as it relates to lifestyles and obesity and all that stems from it.

Conclusion

One of the realities of human existence is that with aging comes a decline in health. Beyond this there is the mystery component as to why certain diseases exist and are born anew in the offspring of individuals through DNA. People grapple with the hardship and pain associated with these diseases. Yet, there are economic and environmental circumstances that exacerbate some of these health challenges. One may not think of these mitigating factors or one may very will acknowledge it privately but be indifferent to it in the public sphere. The end result is that some of the health care hardship can be minimize when both the institutions of society and individual self-determination are both working in harmony. As for people of faith, more is needed than the correct diagnosis and an able and articulate expositor. A prophetic voice must emerge and challenge governments and institutions to make available institutional health components to better serve all of God's people that will in turn aid people grappling with health issues, in this context, healthy lifestyles and eating habits.

> Whether you are sitting in a clinic in rural Haiti, and thus a witness to stupid deaths from infection, or sitting in an emergency room in a U. S. city, and thus the

[41] Rebecca S. Chapp and Duane F. Parker, "Liberation Theology and Pastoral Theology," in *Journal of Pastoral Care Publication* (Decatur, GA: Roundtree Press, 1990), 3.

> provider of first resort for 49 million uninsured, you must acknowledge that the commodification of medicine invariably punishes the vulnerable.[42]

Preachers of the gospel and people of faith must continue to rise and challenge such institutions while at the same time acknowledging each individual's own culpability in one own health life style choices that one can address without the help of others. The prophetic element of challenging institutions must be wedded with the praxis of rising to meet the challenges. Liberation theology cannot be untangled totally from health care. "Some economic systems are patently more pathogenic than others and should be denounced as such by physicians."[43] These physicians are not just in the medical field but for also the physicians of the soul.

When the subject of the human condition is discussed theologically, it is mostly done so in the context of soteriology. It speaks to the human condition of the sinful nature of humankind. It addresses how the work of Christ is brought to bear in atonement and the offering of the forgiveness of sins. This is so because of the work of Christ serving as the sacrificial lamb offering redemption to all who confess, believe in Christ and make the commitment to order their steps in the ways of Christ. The human condition can speak to another aspect of the existential nature of people – be they people of faith or not. By this I mean the human condition that people face trying to eke out an existence in a mean world. This also means trying to navigate a maze of life circumstances. Some of these circumstance deals with the challenges of health. More specifically, in the context of health and wholeness, the human condition of many is filled with being trapped, or so

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[42] Paul Farmer, "Health, Healing and Social Justice: Insights from Liberation Theology," in *The Preferential Option for the Poor Beyond Theology*, eds Daniel G. Groody and Gustavo Gutierrez (Notre Dame, IN: University of Notre Dame Press, 2004, 213.

[43] Farmer, "Health, Healing and Social Justice," 213.

it seems, in a lifestyle of bad eating habits, undesirable health care (if any at all) and physical inactivity. How then is preaching to address this? "One of the reasons preachers struggle with proclaiming God's good news in relation to the human condition is that they haven't necessarily come to terms with the claim that there is a human condition."[44]The human condition is something in which people live and grapple with daily that is in a different sphere from sin and salvation.

> Preachers must know then, that evil and suffering are not temporary elements of humanity's evolution, just about to be eliminated by the new reform, the last formula, the fresh panacea. To those who have tasted grief and smelt the fire such easy preaching and such confident solutions are a grave offense. They know that evil is an integral part of our universe; suffering and enduring the element of the whole.[45]

The human condition is real. A part of its orbit is health and wholeness. The gospel of Jesus Christ should offer a word here of not only a belief system of theology but also a way out or through (praxis) that offers hope and healing.

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[44] O. Wesley Allen, Jr., "Preaching and the Human Condition," *Encounter* 75, no. 3 (2015): 55-69.

[45] Albert Parker Fitch, *Preaching and Paganism* (New Haven, CT: Yale University Press, 1920), 17-18.

CHAPTER FIVE

THEORETICAL FOUNDATIONS

Introduction

The researcher's current context is concentrated within the African Methodist Episcopal Church. More specifically, her contextual focus is the health of the people within the South Savannah District of the Old Georgia Conference of the Sixth Episcopal District within the African Methodist Episcopal Church. Her overall goal is to teach pastors and their congregants healthy lifestyle behaviors as a means to begin the change necessary to move toward optimal cardiovascular health.

It is not surprising that many Americans are living with heart disease and are at risk for heart attacks and strokes. The current American lifestyle revolves around a diet high in fats and carbohydrates, served in portion sizes that are more than twice the recommended amounts. One only as to pay attention to current sitcoms, promotional ads, reality television, and the news programs to see the outward results of such a lifestyle. Unfortunately, this lifestyle has profound pathological effects that go beyond the visible effects often displayed in these venues. These pathological effects include diseases of the heart and great vessels, the pulmonary circulation, cerebrovascular system, arteries,

arterioles, capillaries, veins, lymph nodes, and lymphatic system, which together are classified as cardiovascular disease.[1]

Cardiovascular disease (CVD) is comprised of any of the major disorders of the heart and major blood vessels, including hypertensive diseases, ischemic heart disease, and cerebrovascular diseases.[2] It is commonly manifested as chronic illnesses such as high blood pressure, heart attacks, chest pain, heart failure, and strokes. Over 92 million adults, or one in every three adults in the United States, have one or more types of CVD.[3]

Chronic illnesses, especially cardiovascular diseases, are a major public health problem for African Americans. Not only do these diseases have high mortality rates, but they also account for an increasing amount of disability among this population. Based on 2014 statistics, compared to their white and Hispanic counterparts, African Americans have rates 1.40 times higher or more for high blood pressure and 1.67 times higher or more for stroke.[4] Additionally, although whites suffer slightly higher rates of heart disease (11.1% vs. 10.3%) and coronary heart disease (5.6% vs. 5.5%) compared to African Americans, mortality from CVD[5] is considerably higher among both male and female African Americans.

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[1] Darwin Labarthe, *Epidemiology and Prevention of Cardiovascular Diseases: A Global Challenge* (Sudbury, MA: Jones & Bartlett Publishers, 2010), 4-5.

[2] Labarthe, *Cardiovascular Diseases,* 4-5.

[3] Emelia J. Benjamin et al., "Heart Disease and Stroke Statistics—2017 Update: A Report from the American Heart Association, On behalf of the American Heart Association Statistics Committee and Stroke Statistics Subcommittee," *Circulation* 135, no. 10 (March 2017): 204.

[4] Benjamin et al., "Heart Disease and Stroke Statistics," 205.

[5] Benjamin et al., "Heart Disease and Stroke Statistics," 205.

Despite many medical advances in the treatment of CVDs, African Americans face a greater risk for and suffer hugely from the effects of these diseases. Their complications are both more frequent and more severe, and their overall health outcomes are poorer than all other groups. These poor health outcomes and complications are often exacerbated by disparate treatment, including not being treated according to standard practices and decreased access to care. In many cases, however, poor outcomes are related to poor lifestyle choices including obesity, physical inactivity, and poor adherence to medical treatment programs.

Health behavior and health promotion theories originate from the social and behavioral sciences and provide ways to change behavior in the individual, organizational, and community levels.[6] These theories can assist both the leaders and congregants of the church in developing ways to move into health promotion activities using these different levels. More specifically, health promotion "is the science and art of helping people change their lifestyle toward a state of optimum health. Lifestyle changes can be facilitated by a combination of efforts to enhance awareness, change behavior, and create environments that support good health practices."[7]

Health promotion is the combination of all actions taken by individuals, families, communities, and populations to improve, maintain, and/or return these groups to optimal health. It includes preventive measures and health protection and is not limited to

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[6] Karen Glanz and Barbara Rimer, "Theory at a Glance: A Guide for Health Promotion Practice," 2nd Ed. National Cancer Institute, National Institutes of Health, U.S. Department of Health and Human Services. NIH Pub. No. 05-3896 (Washington, DC: NIH, September 2005), 4.

[7] Karen Glanz, Barbara Rimer and K. Viswanath, eds., *Health Behavior and Health Education: Theory, Research, and Practice*, 4th Ed. (San Francisco, CA: Jossey-Bass, 2008), 11.

treatment(s) by healthcare providers or in health maintenance facilities, but has at its core those lifestyle changes that are most favorable to preserving a healthy state. Health promotion looks at the well-being of the entire individual or group, not just treating disease states. While looking at prevention, health promotion also has a broader focus. It requires individuals and populations to act on their own behalf to protect themselves against health threats. It places a responsibility on them for maximizing safety, resistance, vitality, and functioning. Disease prevention tends to have an "illness" approach with a negative outlook, while health promotion has a "wellness" view with a positive perspective. It encourages people to take control of factors that affect their health, the health of their families, and the health of their communities.

Moving toward optimal health then requires change in health behaviors. Behavioral change is necessary to move from pathological states to wellness. Health behavior theories help explain how this behavior change takes place. They are also used to design interventions to facilitate change on all levels.[8]

This document will first explore the spiritual basis of health and health care as a foundation. Next, it will explore several specific health behaviors/lifestyles which warrant change. Finally, it will describe two health behavior/health promotion theories that may be used to motivate pastors and congregations to change their current behaviors for healthier behaviors.

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[8] Karen Glanz, Frances Marcus Lewis, and Barbara K. Rimer, *Health Behavior and Health Education: Theory, Research, and Practice.* (San Francisco, CA: Jossey-Bass, 1990), 17.

Theoretical Foundations in Ministry Practice

Taking care of congregations has been the role of pastors even prior to the foundation of Christianity. Christian heritage traces its roots back to its biblical forefathers who took care of every need of the people entrusted to them. From Abram to Isaac and through to the prophets, care for the people was in the hands of the leaders of the people. Even Noah and Adam were entrusted with the care of the first families of the world. This care began as stewardship for the things and people God created.[9]

Care then, began as a global concept. The religious leader cared not just for the provision of food and shelter, but also for the safety and health of everyone under their authority, from family members to servants. This tradition continues today. The pastor cares for the entire congregation. And just as he or she cares for the whole congregation, each member is cared for holistically. Pastors of today work to ensure the needs of their congregations are being met. Many denominations have a variety of ministries to assist members with both spiritual and physical needs, including their health and healthcare needs.

Generally speaking, meeting health and healthcare needs is a reactive response. As members become ill or ailing, the church's ministries will kick into high gear. Assistance for the member may begin with the church leadership. The pastor, congregation, and the "prayer warriors" will "lift up" its sick members to Jesus for healing. Visitation of the sick may include the laying on of hands, anointing with oil, or administering communion. The church's response to those with healthcare needs is

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[9] Robert L. Sevensky, "The Religious Foundations of Health Care: A Conceptual Approach," *Journal of Medical Ethics* 9 (1983): 165.

fragmentary in that it will only provide a religious response even though a medical or psychological response may be warranted.[10] The main focus of this traditional response to healthcare in church is on meeting the spiritual needs of its membership.

The church's spiritually based response is deeply rooted in its history. Koenig, King, and Carson[11] note that the word *spiritual* has its origins in Christianity and was used to describe one who the Spirit of God dwelled within. They note as well that the words use and history have continued to be associated with religion until recent years.[12] Often used interchangeably with religion, spirituality is related to the sacred, while religion denotes the doctrine and customs underlying specific traditions.[13]

Lifestyle

Dietary changes, physical activity, and overall obesity reduction are important factors for reducing cardiovascular disease risks. Less than optimal nutrition has been shown to increase mortality and disability.[14] Poor nutrition is also related to CVDs, diabetes and obesity.[15] Increasing consumption of fruits and vegetables, lean meats, nuts

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[10] Chris Schlauch, "Sketching the Contours of a Pastoral Theological Perspective: Suffering, Healing, and Reconstructing Experience," *The Blackwell Reader in Pastoral and Practical Theology*, eds. James Woodward and Stephen Pattison (2000): 213.

[11] Harold G. Koenig, Dana E. King, and Verna Benner Carson, *Handbook of Health and Religion*, Second Edition (Oxford, UK: Oxford University Press, 2012), 45.

[12] Koenig, et al., *Handbook of Health and Religion*, 45.

[13] David O. Moberg, "Spirituality Research: Measuring the Immeasurable," *Perspectives on Science and Christian Faith* 62, no. 2 (June 2010): 102.

[14] Dariush Mozaffarian, "Dietary and Policy Priorities for Cardiovascular Disease, Diabetes, and Obesity: A Comprehensive Review," *Circulation* (January 2016): 187.

[15] Mozaffarian, "Dietary and Policy Priorities," 187.

and legumes, and whole grains, while decreasing intake of processed foods, refined carbohydrates, fats, and salt are food-based priorities.[16]

Excess weight is a major risk factor for the development of cardiovascular disease, diabetes, and other chronic disorders. Obesity is defined as a body-mass index (BMI) of 30 kg/m2 or greater.[17] Sixty-two percent of all women between 20 and 74 were defined as overweight and 34% of these were considered obese. African Americans have been found to be more obese than other ethnic groups. More than three-quarters (76.0%) of African American women between 20 and 74 were classified as overweight and 50.8% of these were classified as obese.[18] Troung[19] found that BMI increases were similar across most ethnic groups except non-Hispanic Blacks, whose weight increased the fastest.

Physical inactivity is associated with increased risk of chronic illnesses, cardiovascular disease, and diabetes and is a major public health problem for African Americans. Principle goals to reduce the exacerbation of each of these diseases and/or

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[16] Mozaffarian, "Dietary and Policy Priorities," 212.

[17] Katherine Flegal, M. Katherine, Margaret D. Carroll, Cynthia L. Ogden, and Lester R. Curtin. "Prevalence and Trends in Obesity Among US Adults: 1999-2008." *Journal of the American Medical Association* 303, no. 3 (2010): 236.

[18] United States. Department of Health and Human Services. Office on Women's Health. *The Health of Minority Women* (Washington, DC: National Women's Health Information Center, July 2003), 9.

[19] Khoa Dang Truong and Roland Sturm, "Weight Gain Trends Across Sociodemographic Groups in the United States," *American Journal of Public Health* 95, no. 9,(2005): 1605.

complications from them are weight reduction and increased physical activity.[20,21,22,23,24] Thirty minutes of physical activity five days per week is the current recommendation and has been effective in reducing risks.[25] Engaging in moderate physical activity has been found to be important in reducing overall mortality rates, the risk for coronary heart disease, diabetes mellitus, several cancers, hypertension, depression, osteoporosis, osteoarthritis, and obesity.[26]

The combination of exercise and diet yields greater and more sustained weight loss in obese subjects.[27] Unfortunately, difficulties in achieving both weight loss and following a prescribed diet have been identified by clients and health care providers as the number one problem in diabetes maintenance and control.[28]

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[20] JoAnne Banks-Wallace and Vicki Conn, "Interventions to Promote Physical Activity Among African American Women," *Public Health Nursing* 19, no. 5 (2002): 322.

[21] Gwen M. Felton, Marlyn D. Boyd, Monina G. Bartoces, and Abbas S. Tavakoli, "Physical Activity in Young African American Women," *Health Care for Women International* 23, no. 8 (2002): 905-918.

[22] Mary A. Nies, Heather L. Chruscial, and Joseph T. Hepworth, "An Intervention to Promote Walking in Sedentary Women in The Community," *American Journal of Health Behavior* 27, no. 5 (2003): 524-535.

[23] Mary A. Nies, Michael Vollman, and Thomas Cook, "African American Women's Experiences with Physical Activity in Their Daily Lives," *Public Health Nursing* 16, no. 1 (1999): 23-36.

[24] Manoj Sharma, Leslie Sargent, and Richard Stacy, "Predictors of Leisure-Time Physical Activity Among African American Women," *American Journal of Health Behavior* 29, no. 4 (2005): 352-359.

[25] Jeff S. Volek, Jaci L. VanHeest, and Cassandra E. Forsythe, "Diet and exercise for weight loss." *Sports Medicine* 35, no. 1 (2005): 1-9.

[26] Sharma, “Predictors of Leisure-Time Physical Activity,” 355.

[27] Barbara Fletcher, Meg Gulanick, and Cindy Lamendola, "Risk Factors for Type 2 Diabetes Mellitus," *Journal of Cardiovascular Nursing* 16, no. 2 (2002): 17-23.

[28] M. E. Wierenga and K. L. Wuethrich, "Diabetes Program Attrition-Differences Between 2 Cultural Groups," *Health Values* 19, no. 3 (1995): 12-21.

Health Promotion Theories

Health Belief Model

One of the earliest health behavior theories is the Health Belief Model (HBM). Dating back to the 1950s, the Health Belief Model was developed by social psychologists Godfrey Hochbaum, Irwin Rosenstock, and Stephen Kegels in response to the failure of a free tuberculosis (TB) health screening program.[29]

The Health Belief Model focuses on the attitudes and beliefs of individuals in order to predict health behaviors. It has been adapted to explore a variety of long and short-term health behaviors. The Health Belief Model is based on the understanding that a person will take a health-related action if that person feels that a negative health condition can be avoided, has a positive expectation that by taking the recommended action, he/she will avoid a negative health condition; and believes that he/she can successfully take a recommended action.

The first concept, *Perceived Susceptibility*, is how likely one believes they are to get a condition. African Americans are more likely to develop hypertension than Whites, so much so that being African American is a risk factor for the disease. African Americans are also more likely to be overweight than other ethnic groups. Because of the prevalence of obesity in African Americans as an ethnic group, the risk for hypertension is increased. African American women are at greater risk, both for developing hypertension and obesity than white women. However, many African American women's

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[29] Deborah L. Finfgeld, Suporn Wongvatunyu, Vicki S. Conn, Victoria T. Grando, and Cynthia L. Russell. "Health Belief Model and Reversal Theory: A Comparative Analysis," *Journal of Advanced Nursing* 43, no. 3 (2003): 288-297.

reference for “normal body weight” was much larger than the standard indicator for weight. These women define weight in terms of their cultural, social and individual context.[30] Their perceived susceptibility may therefore be lower than one might expect.

Perceived Severity is how serious one believes a condition and complications from the condition are. Although diabetes is a very serious disease with many complications, many African Americans do not perceive diabetes as a health threat, but more as a threat to “appearance.” Ford, Havstad, Brooks, and Tilley[31] found that African American participants indicated that they perceived diabetes as a “disfiguring disease” associated with a great number of losses, including loss of vision, limbs, sexuality, and youth.

Perceived Benefits are one’s beliefs in the effectiveness of specified behaviors to decrease risk of a condition or complications from the condition. Nies, Vollman, and Cook[32] found that facilitators to physical activity for African American women were daily routine, practical and convenient activities, personal safety, child care, weight loss, knowledge and commitment, enjoyment, pets, family and peer support, home and work facilities, and daylight and climate conditions. Self-efficacy, social support from family and friends, and enjoyment play a crucial role in its adoption and maintenance.

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[30] Shirley V. Gore, "African-American Women's Perceptions of Weight: Paradigm Shift for Advanced Practice," *Holistic Nursing Practice* 13, no. 4 (1999): 71-79.

[31] Marvella E. Ford, Suzanne L. Havstad, Bobbi L. Brooks, and Barbara C. Tilley, "Perceptions of Diabetes Among Patients in An Urban Health Care System," *Ethnicity and Health* 7, no. 4 (2002): 243-254.

[32] Mary A. Nies, Michael Vollman, and Thomas Cook, “African American Women's Experiences with Physical Activity in Their Daily Lives," *Public Health Nursing* 16, no. 1 (1999): 23-36.

Perceived Barriers are one's beliefs about the costs of achieving the specified behaviors. These costs can be physical, psychological, social, financial, and spiritual. Studies found that barriers to physical activity were lack of child care, no person to exercise with, competing responsibilities, lack of space in the home, inability to use exercise facilities at work, lack of motivation, fatigue, and unsafe neighborhood;[33] lack of time, lack of money, lack of facilities;[34] and personal factors, such as excessive body weight, fatigue, health status, lack of time, lack of freedom and motherhood.[35]

Green, et al reported that 59% of African Americans sampled believed in fate and destiny and that these beliefs influenced their health behaviors.[36] This fatalistic attitude serves as a barrier when health maintenance and/or preventive behaviors are not employed because patients feel they are going to die no matter what they do.

Cues to Action and *Self-efficacy* are added concepts to the Health Belief Model. Cues to Action activate the patient's readiness and stimulates overt behavior. Self-efficacy is one's confidence in the ability to successfully perform an action.[37] Self-efficacy has been found to be a strong contributor to exercise behavior. Exercise self-

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[33] Nies, et al., "African American Women Experiences with Physical Activity," 22-36.

[34] Cynthia M. Castro, James F. Sallis, Sara A. Hickmann, Rebecca E. Lee, and Audrey H. Chen, "A prospective study of psychosocial correlates of physical activity for ethnic minority women," *Psychology and Health* 14, no. 2 (1999): 277-293.

[35] Gwen M. Felton, Marlyn D. Boyd, Monina G. Bartoces, and Abbas S. Tavakoli, "Physical activity in young African American women," *Health Care for Women International* 23, no. 8 (2002): 905-918.

[36] Green, B. Lee, Rhonda K. Lewis, Min Qi Wang, Sharina Person, and Brian Rivers, "Powerlessness, Destiny, and Control: The Influence on Health Behaviors of African Americans," *Journal of Community Health* 29, no. 1 (2004): 15-27.

[37] Finfgeld, et al., "Health Belief Model and Reversal Theory," 288-297.

efficacy is the belief that an individual has the ability to achieve a given exercise goal. It has been concluded that exercise adherence is most affected by the belief that one can make oneself exercise regularly in the face of numerous obstacles.[38]

Transtheoretical Model/Stages of Change

The Transtheoretical Model (TTM) or Stages of Change Model is used to describe a person's motivational readiness or progress towards modifying the problem behavior. In general, voluntarily change occurs only when people feel they need to change or they become convinced that the change is in their best interest or that it will benefit them more than cost them. It requires that they have an organized plan of action that they are committed to implementing. This will allow them to take the actions that are necessary to both make the change and to sustain the change.

The Stages of Change Model provides a framework for understanding and segmenting the process of behavior change. It views motivation as a state of readiness to move through the stages of change and it proposes a predictable pathway for behavior change. The Stages of Change Model is based on six key concepts: pre-contemplation, contemplation, preparation, action, maintenance, and relapse. Within each stage is a specific goal, as well as specific tasks.

Pre-contemplation is the state in which there is little or no consideration of change of the current pattern in the foreseeable future. The person is unaware, unwilling, or too

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[38] Tanya R. Berry and Bruce L. Howe, "The Effects of Exercise Advertising on Self-Efficacy and Decisional Balance," *American Journal of Health Behavior* 29, no. 2 (2005): 117-126.

discouraged to change within the next six months.[39] Tasks of the pre-contemplation stage are to increase awareness of need for change and concern about the current pattern of behavior and to help the individual envision the possibility of change. The goal is that they seriously consider change of the current behavior.

Contemplation is the stage in which the individual examines their current pattern of behavior and the potential for change in a risk-reward analysis. The person in this stage is thinking about making a change in their behavior within the next six months.[40] The tasks are analysis of the pros and cons of the current behavior pattern, as well as, the costs and benefits of change, and finally, making a decision. The goal is a considered evaluation of their behavior that leads to a decision to change.

Preparation is the stage in which the individual makes a commitment to take the necessary action to change their behavior pattern. They will develop a plan and strategy for change. The person is seriously considering change and is planning to change a behavior within 30 days. They have taken steps toward change. The tasks are increasing commitment and creating a viable, realistic, change plan. The goal is an action plan that will be implemented in the near future.

Action is the stage in which the individual implements the plan and takes steps to change the current behavior pattern and to begin creating a new behavior pattern. The person is actively doing things to change or modify behavior.[41] The tasks of this stage are

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[39] John C. Norcross, Paul M. Krebs, and James O. Prochaska, "Stages of Change," *Journal of Clinical Psychology* 67, no. 2 (2011): 144.

[40] Norcross, “Stages of Change,” 144.

[41] Norcross, “Stages of Change,” 144.

implementing strategies for change, revising the plan as needed, and sustaining their commitment in the face of difficulties. The goal is successful action to change current pattern. A new pattern of behavior is established over a significant period of time, generally about three to six months.

Maintenance is the stage where the new behavior pattern is sustained for an extended period of time and is consolidated into the lifestyle of the individual. The person continues to maintain behavioral change for at least six months until it becomes permanent. [42]The tasks are sustaining change over time and across a wide range of different situations and avoiding slips and relapses back into the old pattern of behavior. The goal is long-term sustained change of the old behavior pattern and establishment of a new pattern of behavior.

Relapse is the stage in which the individual slips, regresses, relapses and recycles through the stages. The person returns to the pattern of behavior that she/he had begun to change and thus returns to one of the first three stages. Regression represents movement backward through the stages, while slips are brief returns to the prior behavior that represent failures of action or the action plan. Relapse is a return to re-engagement in the precious behavior to a significant degree after initial success. After returning to the prior status quo behavior, individuals re-enter pre-action stages at pre-contemplation, contemplation, or preparation and may feel like a failure and discouraged about their ability to change.

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[42] Norcross, “Stages of Change,” 144.

Conclusion

The goal of this project is to teach pastors and their congregants healthy lifestyle behaviors as a means to begin the change necessary to move toward optimal cardiovascular health. The current American lifestyle revolves around a diet high in fats and carbohydrates, served in portion sizes that are more than twice the recommended amounts. At the same time, many Americans are sedentary. The combination of these unhealthy patterns has produced an obese society with many who suffer various chronic illnesses.

The global concept of care is not new. The religious leaders of old provided food and shelter, as well as safety and health resources for all under their authority. Pastors of today work to ensure the needs of their congregations are being met as well. The traditional response to meeting health and healthcare needs is reactive in that resources are allocated after a health challenge takes place. The main focus of this traditional response to healthcare in church is on meeting the spiritual needs of its membership.

Often used interchangeably with religion, spirituality is related to the sacred, while religion denotes the doctrine and customs underlying specific traditions.[43] The church's response to those with healthcare needs is fragmentary in that it will only provide a religious response even though a medical or psychological response may be warranted.[44]

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[43] David O. Moberg, "Spirituality Research: Measuring the Immeasurable?" *Perspectives on Science and Christian Faith* 62, no. 2 (June 2010): 102.

[44] Chris Schlauch, "Sketching the Contours of a Pastoral Theological Perspective: Suffering, Healing, and Reconstructing Experience," in, *The Blackwell Reader in Pastoral and Practical Theology*, eds. James Woodward, Stephen Pattison and John Patton (Oxford, UK: Wiley-Blackwell Publisher, 2000), 213.

Cardiovascular disease (CVD) is any of the major disorders of the heart and major blood vessels, including hypertensive diseases, ischemic heart disease, and cerebrovascular diseases.[45] It is commonly manifested as chronic illnesses such as high blood pressure, heart attacks, chest pain, heart failure, and strokes.

Among African Americans, these diseases have high mortality rates and account for an increasing amount of disability among this population. African Americans suffer with high blood pressure rates that are 1.40 times higher than their white counterparts. Stroke rates are 1.67 times higher among this population.[46] CVD mortality rates [47] are considerably higher among both male and female African Americans as well.

These poor health outcomes and complications are often exacerbated by disparate treatment, including not being treated according to standard practices and decreased access to care. In many cases, however, poor outcomes are related to poor lifestyle choices including obesity, physical inactivity, and poor adherence to medical treatment programs.

Using Health behavior and health promotion theories, the author's goal is to assist both the leaders and congregants of the church in developing ways to move into health promotion activities to improve, maintain, and/or return these groups to optimal health.

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[45] Labarthe, *Cardiovascular Diseases,* 4-5.

[46] Benjamin et al., "Heart Disease and Stroke Statistic," 205.

[47] Benjamin et al., "Heart Disease and Stroke Statistics," 205.

These theories originate from the social and behavioral sciences and provide ways to change behavior on multiple levels.[48] Health promotion looks at the well-being of the entire individual or group. It looks at prevention by requiring individuals and populations to act on their own behalf to protect themselves against health threats. And, it encourages people to take control of factors that affect their health, the health of their families, and the health of their communities. Achieving these goals requires changes in health behaviors. Health behavior theories help explain how this behavior change takes place.

Two major health behavior theories are the Health Belief Model and the Transtheoretical Model, also known as the Stages of Change Model. The Health Belief Model focuses on the attitudes and beliefs of individuals in order to predict health behaviors. Its six concepts are Perceived Susceptibility, Perceived Severity, Perceived Benefits, Perceived Barriers, Cues to Action, and Self-Efficacy. Perceived Susceptibility is one's belief in the chances of getting a condition. Perceived Severity is one's belief of how serious a condition and its consequences are. Perceived Benefits reflect one's belief in the efficacy of the advised action to reduce risk or seriousness of impact. Perceived Barriers are one's belief in the tangible and psychological costs of the advised behavior. Cues to Action are the strategies used to activate "readiness" to change. Finally, Self-Efficacy relates to confidence in one's ability to take action.

The Transtheoretical Model (TTM) or Stages of Change Model is used to describe a person's motivational readiness or progress towards modifying the problem behavior. In general, voluntary change occurs only when people feel they need to change or they

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[48] Karen Glanz and Barbara Rimer, *Theory at a Glance: A Guide for Health Promotion Practice*. 2nd ed. National Cancer Institute, National Institutes of Health, U.S. Department of Health and Human Services. NIH Pub. No. 05-3896 (Washington, DC: NIH, September 2005), 4.

become convinced that the change is in their best interest or that it will benefit them more than cost them.

The Stages of Change Model provides a framework for understanding and segmenting the process of behavior change. It is based on six key concepts: pre-contemplation, contemplation, preparation, action, maintenance, and relapse. Within each stage is a specific goal, as well as specific tasks. In pre-contemplation, one is not ready to change. In contemplation, one is thinking about change. In preparation, one is getting ready to make a change. In the action stage, one is actually making the change. In the maintenance stage, one is sustaining the behavior change until it is integrated into lifestyle. In relapse, one is slipping back into previous behavior and re-entering the cycle of change.

Health behavior/health promotion theories are used to facilitate change. These theories will be used to motivate pastors and congregations to change their current behaviors for healthier behaviors.

CHAPTER SIX

PROJECT ANALYSIS

Methodology

Hypothesis

The hypothesis of this research is that pastors and congregants who participate in this project will be able to identify healthy behaviors, feel confident in their ability to maintain a healthy lifestyle and potentially increase their cardiovascular health through weight loss, lowered blood pressure, and decreased cholesterol over time.

Cardiovascular disease is a predominant source of death and disability in the U.S. Included in the term are several lifestyle behaviors which directly and indirectly affect cardiovascular health leading to a prevalence for heart diseases, heart failure, heart attacks, strokes, and death. African Americans are among the poorest in cardiovascular health in this country while leading the pack in physical inactivity, poor dietary patterns, and obesity.

Physical health has been shown to have both direct and indirect associations to spiritual health. Our bodies as temples are subject to the ravages of time. Yet, like any other "building," if the body is not cared for, it becomes damaged and falls apart. When our physical health deteriorates, spiritual health often tends to follow. Many in poor

physical health tend to remain at home to worship rather than in communal fellowship. Poor health, then, can also keep one in isolation from the body of Christ.

This lack of lifestyle management, combined with health disparities and decreased health maintenance, ensures that many African Americans will continue to suffer from the ravages of cardiovascular and other diseases in the future. Congregants of the AME Church are included in the number of those suffering and dying for lack of knowledge and lack of focus. If we are unable to return to our social justice roots and move from a health paradigm of disease treatment to one of disease prevention, the number of health-related diseases will continue to grow among this group.

Pastors are in the perfect position to affect this transition for their congregations. Jesus taught us that sheep follow their shepherd. They know his voice and follow his lead. In the context of today's church, this is also true. Congregations follow where their pastors lead. As leaders of the church, pastors are empowered to lead and also to heal. In the book of Matthew, Jesus gives a clear mandate to heal his people. Providing tools that will engage pastors and their congregations in lifestyle management will ultimately begin the healing process.

Intervention

A higher than average percentage of congregants from the AME Church are at increased risk of death and infirmity from cardiovascular disease and other chronic illnesses. Chronic illnesses, especially cardiovascular diseases, are a major public health problem for African Americans. Not only do these diseases have high mortality rates, but they also account for an increasing amount of disability among this population. Based on

2014 statistics, compared to their white and Hispanic counterparts, African Americans have rates 1.40 times higher or more for high blood pressure and 1.67 times higher or more for stroke.[1] Additionally, although whites suffer slightly higher rates of heart disease (11.1% vs. 10.3%) and coronary heart disease (5.6% vs. 5.5%) compared to African Americans, mortality from CVD[2] is considerably higher among both male and female African Americans.

Despite many medical advances in the treatment of CVDs, African Americans face a greater risk for and suffer hugely from the effects of these diseases. Their complications are both more frequent and more severe, and their overall health outcomes are poorer than all other groups. These poor health outcomes and complications are often exacerbated by disparate treatment, including not being treated according to standard practices and decreased access to care. In many cases, however, poor outcomes are related to poor lifestyle choices including obesity, physical inactivity, and poor adherence to medical treatment programs.

Health behavior and health promotion theories originate from the social and behavioral sciences and provide ways to change behavior on the individual, organizational, and community levels.[3] These theories can assist both the leaders and congregants of the church in developing ways to move into health promotion activities

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[1] Emelia J. Benjamin et al., "Heart Disease and Stroke Statistics—2017 Update: A Report from the American Heart Association, On behalf of the American Heart Association Statistics Committee and Stroke Statistics Subcommittee," *Circulation* 135, no. 10 (March 2017): 205.

[2] Benjamin et al., "Heart Disease and Stroke Statistics."

[3] Karen Glanz and Barbara Rimer, "Theory at a Glance: A Guide for Health Promotion Practice," 2nd Ed. National Cancer Institute, National Institutes of Health, U.S. Department of Health and Human Services. NIH Pub. No. 05-3896 (Washington, DC: NIH, September 2005), 4.

using these different levels. More specifically, health promotion "is the science and art of helping people change their lifestyle toward a state of optimum health. Lifestyle changes can be facilitated by a combination of efforts to enhance awareness, change behavior, and create environments that support good health practices."[4]

Health promotion is the combination of all actions taken by individuals, families, communities, and populations to improve, maintain, and/or return these groups to optimal health. It includes preventive measures and health protection, and is not limited to treatment(s) by healthcare providers or in health maintenance facilities, but has at its core those lifestyle changes that are most favorable to preserving a healthy state. Health promotion looks at the well-being of the entire individual or group, not just treating disease states. While looking at prevention, health promotion also has a broader focus. It requires individuals and populations to act on their own behalf to protect themselves against health threats. It places a responsibility on them for maximizing safety, resistance, vitality, and functioning. Disease prevention tends to have an "illness" approach with a negative outlook, while health promotion has a "wellness" view with a positive perspective. It encourages people to take control of factors that affect their health, the health of their families, and the health of their communities.

Moving toward optimal health then, requires change in health behaviors. Behavior change is necessary to move from pathological states to wellness. Health behavior

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[4] Karen Glanz, Barbara Rimer and K. Viswanath, eds., *Health Behavior and Health Education: Theory, Research, and Practice*, 4th Ed. (San Francisco, CA: Jossey-Bass, 2008), 11.

theories help explain how this behavior change takes place. They are also used to design interventions to facilitate change on all levels.[5]

The purpose of the project was to design, implement, and evaluate a four-week healthy lifestyle teaching project for the pastors and congregants of the Savannah South District of the AME Church. A healthy lifestyle was defined as a lifestyle which includes: thirty minutes of physical activity per day at least five days per week; drinking at least sixty-four fluid ounces of water per day; eating at least five servings of fruits and vegetables a day; and decreasing salt intake to less than 2300 milligrams from all sources per day.

To address the subject of healthy lifestyles, an intervention was designed to train both pastors and congregations and then to assess whether there was a change in health behaviors. Introduction of the project to the members of the West Savannah District (previous name of the Savannah South District), began in February of 2016. Under the leadership of the former presiding elder, the researcher held two classes on cardiovascular health during his District Conference. Simply titled "Health 101, Part A and Part B," these two classes provided an initial overview to the subject of health in general and cardiovascular health, more specifically.

In "Part A," the types of health – including financial, psychological, emotional, spiritual, and physical – were each discussed. Physical health then became the focus of the rest of the session. Ways in which one achieves and maintains physical health were each discussed. These included proper nutrition, physical activity, refraining from

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[5] Karen Glanz, Frances Marcus Lewis, and Barbara K. Rimer, *Health Behavior and Health Education: Theory, Research, and Practice* (San Francisco, CA: Jossey-Bass, 1990), 17.

unhealthy habits such as smoking, alcohol consumption, use of illicit drugs, over use of prescribed medications, and maintaining immunizations and health checkups.

The second class, "Part B," provided a more detailed focus on cardiovascular disease. An overview of risk factors for poor health and heart disease was provided. These risk factors include diet, high blood pressure (even if treated), high cholesterol, diabetes, smoking, obesity, an inactive lifestyle, alcohol, stress, a family history of early heart disease, age (> 55 for women, >45 for men), and chronic kidney disease. Next, the question was poised to the group, "Which of these are out of your hands?" Many of the participants thought that stress and the different disease states were out of their hands. But the reality is that only one's family history and age are beyond one's control. After this discussion, each of the risk factors were discussed in detail. These classes were well received and the presiding elder, as well as the members of the district requested that we have more health information presented.

The project did not begin to move forward again until the fall of 2016. After meeting with the newly appointed presiding elder, the researcher was given permission to continue with the project (See Appendix A). Beginning in January 2017, context associates' planning meetings changed from monthly to biweekly as our project milestones were drawing nearer. Meetings were held via conference call every other Thursday at seven o'clock p.m., beginning the fifth of January.

The first milestone of the intervention was the completion of the pre-surveys for both lay and clergy (See Appendix C and D). The pre-surveys were completed at the end of the Savannah South District Conference (See Appendix I) on January 28, 2017. The pre-surveys included a demographic questionnaire (See Appendix B) and the Health

Behaviors Survey. There were two versions of the Health Behaviors Survey. One version was for laity and one was for pastors (See Appendix C and D). Both the demographic questionnaire and the Health Behaviors Survey were stapled together to form one packet. Each participant was asked to complete the entire packet. Respondents were instructed that the questionnaires were not mandatory and that completing the questionnaires granted consent. They were also instructed not to add their names to any of the questionnaires.

During this District Conference, pastors were also asked to preach on healthy lifestyle behaviors each Sunday in the month of February. A packet of scriptures related to health behaviors (See Appendix H) was provided to give pastors some assistance in finding appropriate scripture to use. Pastors were informed that they were not required to use any scripture from the handout packet. They were also instructed to base their sermon for February 5th on the need for physical activity and/or walking and/or not enough physical activity/walking. For February 12th, their sermon topic was to be related to eating fruits and vegetables and/or not consuming enough fruits and vegetables. The subject for February 19th was drinking water instead of sugary drinks and/or not enough water and/or the benefits of drinking water. The subject for February 26th was decreasing salt intake and/or the harmful effects of too much salt.

The second milestone was the Savannah South District Health Summit. Information on the upcoming Health Summit was also provided during the District Conference held in January. Additionally, the Summit was mentioned at all district calling post meetings and conference calls. The Health Summit flyer (See Appendix I) was also sent out to the district pastors via email.

The Health Summit was titled, “Savannah South District’s IMPACTING Our Health: Implementing Methods for Pastoral And Congregational for Increased Activity and Nutritional Goals for Our Health.” The Summit’s target audience was the members of the Savannah South District, both clergy and laity. However, it was open to anyone who wanted to join us. The Impact Health Summit was held at Bethel AME Church, in Hinesville, Georgia. Hinesville was chosen because it is a city located in the central area of the Savannah South District. Five AME churches are located in the Hinesville/Liberty County area. Bethel was chosen because it is one of the two largest churches, it has one of the largest fellowship halls, and it was available in the projected timeframe.

The format of the Health Summit was similar to a Health Fair in that there were health-related booths set up around the perimeter of the Fellowship Hall. Vendors included two nutrition booths, a caffeine-free coffee vendor, an exercise booth, several food booths and a water station, a blood pressure check station, a blood glucose check station, a free-health care clinic station, a children’s safety booth, a weight-loss garment booth, a sodium comparison booth, and a vegetable spiralizer station.

Participants entered the hall by the front door and were given a goody-bag, a healthy lifestyle journal, and several health-related novelties such as pencils, fruit and vegetable shaped stress balls and note pads. Most of the vendors had a combination of different handouts and/or freebies for the participants to collect and add to their bags. Doors opened at 9 a.m. After a brief welcome and overview, participants were free to roam around the hall to the different booths. The food booths were opened at this time so that participants could enjoy a healthy breakfast while participating in the Summit.

Impact Health Summit

Unlike the traditional health fair, the Impact Summit also included instruction on healthy behaviors/healthy lifestyles. Participants were instructed on increasing exercise/physical activity, increasing fruit and vegetable intake, increasing water intake, and decreasing salt intake. Training sessions began at 10:00 a.m. with a class on decreasing salt intake. This class was taught by a family nurse practitioner (FNP). The next class was on increasing fruit and vegetable intake and was taught by a registered dietician (RD). The third class was on the importance of increasing water intake and was taught by the researcher, a registered nurse (RN). The fourth, and final class was a chair exercise class, taught by a local exercise instructor.

Decreasing Salt Intake

This class discussed the use of salt and the ways it is in the foods one eats. Decreasing salt and sodium are important for the prevention and lowering of high blood pressure. Other names for salt, such as sodium, sodium chloride, monosodium glutamate (MSG), and disodium phosphate were provided to participants. Foods that typically carry high salt/sodium loads were highlighted; some of them are canned goods, frozen and prepared foods, cold cuts/luncheon meats, cheeses, soups, nuts, breads and rolls, and chips and other salty snacks. Participants were informed that one teaspoon of salt contains about 2,300 milligrams (mg) of sodium, which is the recommended daily amount of sodium for the average adult. Ways to eat less salt/sodium were also discussed. These included eating fresh vegetables and fruits instead of salty snacks; buying fresh, frozen, or no-salt-added canned foods, or foods packed in water instead of broths, were

recommended. Eating less processed foods, particularly ham, sausages, hotdogs, and luncheon meats, is also important for reducing the daily amount of sodium consumed.

Increasing Fruit and Vegetable Intake

In this class, the instructor discussed the recommended daily allowance (RDA) of fruits and vegetables as five a day, with at least two servings of fruit and at least three servings of vegetables each day. She also discussed ways in which eating the appropriate servings of fruits and vegetables is beneficial to the individual, including maintaining a healthy weight, decreasing obesity, decreasing the risk of cardiovascular disease, increasing phytonutrients, and increasing fiber, vitamins, and minerals. The five main color groups including red and pink, blue and purple, yellow and orange, white, and green fruits and vegetables were also discussed. Red and pink fruits and vegetables include cherries, cranberries, beets, strawberries, red grapes, red apples, tomatoes, red peppers, and red potatoes. Blue and purple fruits and vegetables include blueberries, blackberries, purple or black grapes, plums, raisins, and eggplants. Yellow and orange fruits and vegetables include squash, carrots, corn, pumpkins, oranges, tangerines and lemons, mangoes, peaches, pineapples, cantaloupe, sweet potatoes and yams, and yellow peppers. White fruits and vegetables include bananas, mushrooms, onions, shallots, cauliflower, garlic, ginger, jicama, kohlrabi, white corn, turnips, white peaches and nectarines. Green fruits and vegetables include limes, green grapes, kiwis, pears, green onions and leeks, artichokes, celery, cucumbers, green beans and peas, green peppers, avocados, asparagus, snow peas, sugar snap peas, watercress, zucchini, okra, and green leafy vegetables such as broccoli, spinach, Brussels sprouts, romaine lettuce, collard

greens, mustard greens, bok choy, green cabbage, and kale. Ways to increase fruit and vegetable consumption include eating fresh fruits and veggies while in season, eating fresh and frozen fruits and vegetables that are packed in 100% juice or washed before use, adding chopped or pureed vegetables to soups and sauces, adding fruit to salads; adding fruits or vegetables to casserole, slow-cooker, and one-pot dishes; adding fruits and vegetables to shakes and smoothies, and using a spiralizer to make vegetable "noodles" instead of regular pastas.

Increasing Water Intake

Water is important to the body for a number of reasons. In this class, participants learned that the body is composed of approximately 60% water. Drinking water helps the body to achieve and maintain the appropriate balance needed to replace water losses through breathing, sweating, and other insensible losses. Hydration, or the proper balance of water in the body, aids in kidney function, digestion and helps prevent and treat constipation, keeps joints and muscles lubricated, and helps prevent injuries such as strains and sprains. Proper hydration also helps prevent and treat obesity by increasing one's sense of fullness, boosting their metabolic rate, and causing less intake of food. Several ways to increase water intake were also discussed. Some of them are keeping water handy (such as in a bottle or pitcher), using an infuser to add flavor to water, eating foods that are water-rich such as cucumbers, zucchini, watermelon, and grapefruit, sipping water prior to each meal, diluting other drinks with water and/or ice prior to drinking, drinking a glass during breaks (including bathroom breaks and commercial

breaks), using sparkling water or mineral water instead of drinking sugary or caffeinated drinks, and using a marked water bottle to track your progress throughout the day.

Exercise Class

The physical activity/exercise class began with an overview of some benefits of exercise. These included weight control and weight loss, decreased risk for cardiovascular disease and diabetes, and increased mobility. The instructor asked participants how many exercised regularly. Most did not. She discussed that only thirty minutes of exercise per day was needed to maintain health. She also reminded the class that this thirty minutes could be broken up in to fifteen or even ten minute segments. The instructor listed many different ways ones could get exercise including running, walking, swimming, biking, water aerobics, hiking, and classes such as Zumba. She also emphasized that just because one is getting older and may be less mobile, one could still get a good aerobic and strength workout using chair aerobics. She then led the group in a chair aerobics class.

The chair exercise class lasted approximately thirty minutes. The instructor used common activities and a variety of patterns and repetitions to provide a thorough workout with the entire class seated in standard folding chairs. The class was set to music in short sets. Each set began at a slower pace and increased over several minutes. Each set had a different theme. For example, one set was washing the car. The music began at a slow pace and participants were instructed to raise their arms in front of themselves with palms facing forward and begin to rotate their arms to the right and then to the left. They were next asked to straighten their arms to the sides and lean over to the right and then to the

left: to dip their hands into the bucket. Other movements were combined with these to make an overall set. Each of the six sets lasted approximately five minutes.

The chair exercise class was the final class of the day. A healthy lunch had been prepared and all participants were invited to join in. While the participants were eating, two food quick and easy healthy food preparation classes were given. Once these classes were finished, the researcher thanked everyone for coming and gave them instruction on completing the post-survey. The Summit ended at 2:00 p.m. The completed post-surveys were dropped in baskets at the exit doors.

Research Design

The goal of the project was to increase the knowledge of pastors and members of the Savannah South District related to healthy-lifestyle behaviors. Although introduced to the District early on, the main focus of the project occurred over approximately six weeks from the end of January to mid-March 2017. A qualitative research design with a mixed methods data collection strategy was used for this project. Qualitative research was chosen because it is taken in the natural setting, is well-suited for exploring social problems and understanding their meaning.[6]

Measurement

Using mixed methods in data collection allowed for triangulation of data in order to strengthen the study. This strategy included the use of a demographic questionnaire, a

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[6] John W. Creswell, *Research Design: Qualitative, Quantitative and Mixed Methods Approaches*, 3rd ed. (Los Angeles, CA: Sage, 2009), 14.

pre-and post-survey for laity, a pre-and post-survey for clergy, and structured telephonic interviews (See Appendix G). Data was assessed for credibility using input and evaluation by the context associates. A separate meeting was held to discuss each of the data collection tools.

Instrumentation

The demographic questionnaire (See Appendix B) included information on the age, race, and ethnicity. It also asked various questions about the marital status, educational level, employment, income, and health insurance status of respondents. The data from the demographic questionnaire was used specifically to obtain general background information. This tool was quantitative in nature.

The pre-and post-survey tools "used fixed responses"[7] in a mix of knowledge, behavioral, and opinion questions. Knowledge questions "ask for specific information possessed by the interviewee."[8] Behavioral questions "ask about what people have or have not done."[9] Opinion questions "tell us about people's goals, intentions, desires and values."[10]

The pre-test named "Health Behaviors Survey for Laity" (See Appendix C) was used to measure the lifestyle behaviors currently followed by participants in the laity. The pre-test named "Health Behaviors Survey for Ministers (See Appendix D) was used in

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[7] Tim Sensing, *Qualitative Research: A Multi-Methods Approach to Projects for Doctor of Ministry Theses* (Eugene, OR: Wipf & Stock, 2011), 115.

[8] Sensing, *Qualitative Research*, 88.

[9] Sensing, *Qualitative Research*, 88.

[10] Sensing, *Qualitative Research*, 88.

the same manner as for the laity. This tool included the same questions from the laity survey with an additional five questions related to pastor's views on health and sermons given on healthy behaviors. These five questions were added to the end of the survey tool. The post-survey tools were collected at the end of the Impact Health Summit.

Telephone interviews were conducted among several members of the Savannah South District in the week after the Impact Health Summit. Members contacted were associated with the District's Health Commission. The telephone interviews were structured interviews. Each participant was asked the same questions in the same order. The interviews consisted of five open-ended questions related to the participant's knowledge of healthy behaviors. The researcher used these questions to assess the level of knowledge of those who are charged with presenting health-related programs across the Savannah South District. The five questions included in the interview were: What measures do you use to maintain your health? How often and what type of exercise do you do on a weekly basis? How much water do you drink on a daily basis? How many servings of fruits and vegetables do you eat on a daily basis? And, how much salt/sodium do you consume on a daily basis? (see Appendix G).

Planning for the IMPACT Health Summit

Beginning in January 2017, context associates planning meetings were held biweekly. Meetings were held via conference call every other Thursday at seven o'clock p.m., beginning the fifth of January. The focus of the meeting on January 5th was to reacquaint the context associates with the project. The purpose and an overview of the project were given. Verification of the presiding elder's permission to move forward, as

well as verification of the event location, date, and time were provided. The schedule of the upcoming meetings was also provided.

The second meeting was held on January 19th. The format of the Health Summit was discussed, as well as whether vendors should be included. The committee elected to solicit as many vendors as possible in order to make the atmosphere more like a health fair and thereby encourage participation. The demographic form was reviewed and an electronic copy sent to each participant.

The focus of the third meeting was the pre- and post-survey tools. Potential questions to be used for the tool for the laity were reviewed. The pre- and post-survey tools for laity were finalized on February 2nd and the additional questions for ministers were discussed. These questions were finalized on February 16th. The flyer for the District announcement was also finalized and sent to the presiding elder for distribution. Telephonic interview questions were discussed and finalized on March 2nd.

Collection of Data, Analysis of Data and Outcome

Demographic Data Analysis (See Demographic Chart, Appendix I)

There were thirty-five respondents at the time of the pre-survey. Each of these respondents are unique individuals who bring a variety of experiences into the church. These respondents completed both the demographic form and the Healthy Behaviors Survey. Nearly all respondents were African American (94%) of non-Hispanic descent (97%). Ages ranged from twenty-one to eighty years old with a mean age of fifty-four and a mode of sixty-one. Fifty-one percent of respondents were married and twenty-nine

percent were divorced. All other categories combined (widowed, separated, never married, member of an unmarried couple) were twenty percent.

Responses to the education level questions revealed that most respondents had some college through a doctoral degree (86%). However, 23% had a year or more of college with no degree. There were 20% among those with some college credit, but less than one year and another 20% had a Master's degree. Individually, those with an Associate's degree (11%), a Bachelor's degree (5%), or a Doctoral degree (5%), were fewer than those who had no schooling up to those who were high school graduates (14%).

Income level was varied with most (34%) in the less than $10,000 through the $39,999 range. Income level from $40,000 to $59,000 accounted for another 29% in this population. Income levels from $60,000 to $149,000 accounted for another 29%. Most respondents (57%) were wage earners. Another 17% were retired. Some, such as students (8.5%), overlapped other categories. Those who were self-employed, out of work, or homemakers comprised 23% of this population. See chart below for a more extensive breakdown.

Demographics Chart Total Respondents = 35*		
	Number	**Percentage**
Race		
African American	33	94
White	2	5.7
Ethnicity		
Non-Hispanic	34	97
Hispanic	1	2
Marital Status		
Now married	18	51
Divorced	10	29
All others (Widowed, Separated, Never married, Member of unmarried couple)	7	20
Education Level		
1 or more years of college, no degree	8	23
Some college credit, but less than 1 year	7	20
Master's degree (for example: MA, MS, MEng, MEd, MSW, MBA)	7	20
Associate degree (for example: AA, AS)	4	11
Bachelor's degree (for example: BA, AB, BS)	2	5
Doctorate degree (for example: PhD, EdD)	2	5
No schooling completed through High school graduate	5	14
Some college through Doctorate	30	86
Income Level		
$40,000 to $49,999	5	14
$50,000 to $59,999	5	14
Less than $10,000	3	8
$10,000 to $19,999	3	8
$20,000 to $29,999	3	8
$30,000 to $39,999	3	8
$60,000 to $69,999	3	8
$100,000 to $149,999	3	8
$70,000 through $99,999	4	11
$150,000 or more	1	2
No Response	3	8
Employment Status		
Employed for wages	18	57
Retired	6	17
Self-employed	2	5.7
Out of work and looking for work	2	5.7
Out of work but not currently looking for work	2	5.7
A homemaker	2	5.7
A student	3	8.5
Health Insurance		
Yes	31	88.5
No	4	11

Pre-Test Survey - Laity

The pre-survey tool, the Health Behaviors Survey – Laity, asked a series of healthy behavior related questions to evaluate their knowledge, behaviors, and opinions. The first three questions asked the importance of nutritional content, taste, and ease of preparation when buying food items. Respondents overwhelmingly chose taste (74%) over ease of preparation (60%) and nutritional value (49%). Most (57%) ate fast food once or twice a week, while another 23% ate fast food three or more times per week. Despite consuming fast food between one to three or more times a week, most respondents (31%) believed their salt/sodium consumption to be between 2,300 and 3,400 mg. Another 29% did not respond to this question. Consistent with their fast food consumption, most respondents (40%) reported only eating one to two servings of fruits and vegetables each day, while 34% consumed three to four servings, and 17% ate five or more servings of fruits and vegetables per day.

More than half of respondents (51%) drank one to four sodas per week. Of those that reported drinking water (66%), only 9% drank eight or more glasses of water per day, while 35% drank five to seven glasses of water per day, and 57% drank one to four glasses of water per day. Most respondents reported drinking bottled water (51%) over flavored water (26%) or tap water (17%).

Although most (69%) felt it was very important for structured Physical Education programs at schools, 66% spent less than twice per week exercising for thirty minutes or more. Additionally, the majority (40%) spent five or more hours in sedentary activities such as watching TV, using the computer or phone, or playing video games when not at work. Of the 60% who reported exercise, 33% most often ran, walked, or swam; 24%

most often did aerobic, dance or Zumba classes; 24% most often did strength or weight training; and 19% most often did Yoga or Tai chi. Most respondents (57%) found that time was a barrier to keeping themselves healthy and fit. Only 23% found their finances to be a barrier, while another 17% were unaware of the available resources, and 14% found their lack of interest to be a barrier.

Post-Test Survey Analysis and Comparison - Laity

The post-test survey tool, the Health Behaviors Post-Test – Laity, asked a series of healthy behavior related questions to evaluate knowledge gained, intended changes of behaviors, and opinion changes that occurred during and/or because of the IMPACT Health Summit.

Only nineteen participants responded to the post-test, respondents continued to choose taste (97%) over ease of preparation (76%). However, more respondents (86%) were very likely to believe nutritional value to be very important compared to only 49% in the pre-test. Likewise, the likeliness of eating fast food remained high with most (76%) being likely to eat fast food at least once or twice a week, while only 17% likely to eat fast food three or more times per week. Despite the training, most respondents (31%) still believed the correct limit for salt/sodium consumption was between 2,300 and 3,400 mg per day. Only 6% correctly identified <2,300 mg of sodium per day as the correct limit for salt/sodium consumption. Another 41% did not respond to this question.

Despite their likeliness to continue with fast food consumption, more respondents (52%) were likely to consume three to four servings of fruits and vegetables each day and 20% were likely to consume five or more servings of fruits and vegetables per day. Only

28% responded that they were likely to consume only one to two servings of fruits and vegetables per day.

Fewer respondents were likely to drink sodas than during the pre-test with 24% likely to drink no sodas and more than half of respondents (55%) likely to drink one to four sodas per week. With the likeliness for less soda consumption, most respondents (62%) also indicated that they should consume eight or more glasses of water per day; 24% indicated five to seven glasses of water per day, and 14% indicated that water consumption should be one to four glasses of water per day. No respondent chose 'none' in response to this question. Most respondents still reported preferring more bottled water (52%) over tap water (28%) or flavored water (20%).

The need for structured Physical Education programs at schools gained in importance, with 100% of respondents reporting that they found it to be very important. The majority of respondents (72%) also indicated that they should exercise at least five or more times per week for thirty minutes or more and 28% indicated that they should exercise three to four times per week for thirty minutes or more.

While 24% incorrectly indicated that they should limit watching television, using the computer or phone, or playing video games to between three and four hours, 38% correctly indicated that they should limit watching TV, using the computer or phone, or playing video games to less than two hours, on an average day.

Respondents specified that more planned to run, walk, or swim for exercise (41%); 34% planned to do aerobic, dance or Zumba classes; 20% planned to do strength or weight training; and only 3% planned to do Yoga or Tai chi. Most respondents indicated that (65%) they believed that time would be a barrier to keeping themselves

healthy and fit. Only 17% believed their finances to be a barrier, while another 17% believed their lack of interest to be a barrier. Only 6% believed that their unawareness of the available resources would be a barrier.

Pre- and Post-Test Survey Analysis and Comparison – Ministers

Like the pre-survey tool, for the laity, the Health Behaviors Survey – Ministers asked a series of healthy behavior related questions to evaluate their knowledge, behaviors, and opinions. Along with the questions for the laity, five additional questions related to pastor's views on health and on sermons given related to healthy behaviors. The post-test survey tool, the Health Behaviors Post-Test – Ministers, then, asked a series of healthy behavior related questions to evaluate knowledge gained, intended changes of behaviors, and opinion changes that occurred during and/or because of the IMPACT Health Summit. Four ministers completed both the pre-test and the post-test.

The first three questions asked the importance of nutritional content, taste, and ease of preparation when buying food items. Ministers found nutritional value (100%), taste (100%), and ease of preparation (75%) very important in the pre-test. In the post-test, 100% of ministers believe nutritional value, taste, and ease of preparation to be important. Most ministers (50%) drank one to four sodas per day. Of the other half surveyed, 25% drank no sodas and 25% drank eight or more. After the Health Summit, 50% indicated that they would not likely drink any sodas and 50% indicated that they would be likely to drink only one to four sodas per week. Fast food consumption was across the spectrum, with 25% in each category (never, one to two, three to four, and five

or more). Although 25% felt they were likely to consume fast food one to two and three to four days per week, 50% felt they would not eat fast food.

All ministers believed structured Physical Education Program at school was very important, both pre- and post-test. As for their own habits, in the pre-test, 50% of ministers exercised three to four times per week for 30 minutes or more; 25% exercised one to two times per week; and 25% never exercised. All ministers (100%) correctly indicated that they should exercise five or more times per week for at least 30 minutes each. All ministers were most likely to walk, run, or swim in the pre-test. They (100%) also indicated that they would make an exercise plan to walk, run, or swim. Their barrier to exercise was time (100%) both pre-test and post-test. Only 25% of ministers watched television, used the computer or phone, or played video games for five or more hours per day. Another 25% spent three to four hours in these activities. However, the majority (50%) spent less than one hour per day in these sedentary activities. In the post-test analysis, 75% believed they should spend only one to two hours per day in these activities. The other 25% believed they should spend less than one hour per day watching television, using the computer or phone, or playing video games.

In the pre-test, 50% of ministers drank one to four glasses of water per day, 25% drank five to seven glasses of water per day, and 25% drank eight or more glasses of water per day. After the intervention, 100% indicated that they should consume eight or more glasses of water per day. As for types of water consumed, 50% drank bottled water, 25% drank tap water, and 25% drank flavored water in the pre-test. This did not change post-test. Fifty percent of ministers believed they consumed 2,300 to 3,400 mg of salt/sodium, 25% believed they consumed 3,400 to 4,000 mg, and 25% believed they

consumed more than 4,000 mg of salt/sodium in the pre-test. In the post-test, 75% indicated that they believed they should consume less than 2,300 mg per day, and 25% believed that they should consume 2,300 to 3,400 mg of salt/sodium per day. For servings of vegetables per day, 75% of ministers indicated that they ate three to four servings per day, while 25% indicated that they ate only one to two servings per day. In the post-test, 75% indicated that they should eat five or more servings of fruits and vegetables, while only 25% indicated that they should eat three to four servings of fruits and vegetables per day.

Based on the pre-test in the 'Ministers Only' section, 100% of ministers indicated that physical health was very important to them. Post-test, 100% felt that physical health should be seen as very important. In the pre-test, 100% felt that you needed both physical and spiritual health in order to be healthy. This was verified in the training, and 100% continued to believe that both physical and spiritual health are needed in order to be healthy.

Prior to the classes, 50% did not find it difficult to discuss health related issues with their congregations, but 50% found it somewhat difficult to discuss health related issues with their congregations. After participating in the classes, 100% believed they would not find it difficult to discuss health related issues with their congregations. Most ministers (75%) were already talking about health or health behaviors in their sermons at least quarterly. However, the other 25% was not speaking about health and health behaviors in their sermons. After the training sessions, 50% believed they should be talking about health or health behaviors in their sermons at least monthly. Another 25% believed they should be talking about health or health behaviors in their sermons more

than once per month, and the last 25% believed they should be talking about health or health behaviors in their sermons at least quarterly.

The final question for ministers looked at whether they believed they set an example of good health for their congregations. In the pre-test, 50% felt they set a good example and 50% felt they set a fair example for their congregations. Based on the classes they received, only 25% believed they would only be able to set a fair example of good health for their congregations, while 50% believed they would be able to set a good example of good health for their congregation, and 25% believed they would be able to set an excellent example of good health for their congregation.

Telephonic Interviews – Analysis

Telephone interviews were conducted among several members of the Savannah South District in the week after the Impact Health Summit. These structured interviews consisted of five open-ended questions related to the participant's knowledge of healthy behaviors: What measures do you use to maintain your health? How often and what type of exercise do you do on a weekly basis? How much water do you drink on a daily basis? How many servings of fruits and vegetables do you eat on a daily basis? And, how much salt/sodium do you consume on a daily basis? Four members were interviewed. The following were their responses.

Interviewees main health measures were walking and controlling their dietary intake. Control of intake included attention to calories, fats, carbs, and sodium. Keeping stress to a minimum was also a measure. All interviewees walked as their means of

exercise. One walked occasionally, one once or twice a week. The other interviewees walked three or more miles daily.

Water consumption varied. One interviewee drank less than one bottle per day. One drank one twelve-ounce bottle per day. Another drank two sixteen ounce bottles per day and another drank three or more twenty-four ounce bottles per day.

While all ate fruits and vegetable daily, one interviewee ate only one to two servings per day. The rest ate four or more servings per day. All interviewees denied using much salt. However, all seemed to be unaware of the hidden sources of salt and sodium in common foods. When asked about their sodium intake, interviewees were unable to articulate sources of sodium other than in cooking and adding table salt to foods.

Summary of Learning

This study provided the researcher an opportunity to evaluate the health behaviors and the knowledge of health behaviors on the Savanah South District. The results of the study reveal areas of continued educational need among individuals, churches, and the Savannah South District as a whole. While the results are informative for the Savannah South District, they are not generalizable beyond it because it was developed specifically for this population.

In general, the results show that most of the respondents from the Savannah South District have poor health behaviors. For example, most respondents surveyed ate fast food several times per week, ate less than five servings of fruits and vegetables per day, consumed double or more of the RDA of sodium, drank too much soda and not enough

water, did less than the recommended amount of exercise per day, and found time to be their biggest barrier.

The researcher learned a great deal about the ministers and laity within the Savannah South District. District members were extremely helpful and had no problem helping implement the intervention. One of the things I would change would be the timing of the Health Summit to a time that is less busy for the District as a whole. I would also change some of the questions and the order of the questions. Getting the word out sooner would have been helpful as well. I would also consider adding a spirituality scale to compare change in spirituality as learning increased. All in all, there was a steep learning curve when it came to planning the Summit.

Conclusion

The Health Summit intervention was a fun and informative way to provide health information to a diverse group of laity and ministers. Many verbalized that having the classes during the Summit helped them because they were encouraged to ask questions during the classes. They also enjoyed making their own French dip and parfaits. These two easy recipes were dishes the participants could easily prepare at home and even allow their children and grandchildren to assist with. They also voiced that they enjoyed trying out the healthy foods that had been prepared for their light-lunch. The menu consisted of baked lemon-pepper and honey glazed chicken wings, sweet potato fries, fruit and veggie trays, BBQ roasted chickpeas, avocado hummus with homemade pita chips, and peanut butter Cheerio bars.

Although their knowledge did increase with the intervention, one is unable to discern whether this increased knowledge will lead to action on the part of the participants. These results suggest the need for further educational services for both laity and ministers related to healthy lifestyle behaviors. Ministers seemed to have gained more knowledge than the laity; however, with such a small sample, one may have difficulty gathering enough data to apply it to larger populations. Additionally, a survey tool that queried respondents for information about existing chronic illnesses and specific questions related to knowledge of health behaviors should be included.

Scheduling the intervention during a less busy season of the church might render greater participation and a larger sample. However, due to the many competing commitments of the District churches and its members, both laity and clergy, the Health Summit was sandwiched between several important events. It followed on the heels of the Sixth Episcopal District's Founder's Day Celebration held in neighboring Savannah, Georgia. And, it fell just prior to the Georgia Conference 152nd Annual Conference. This event occurred two weeks after the Health Summit at the same church used for the intervention. With preparation for the Annual Conference in full swing, participation in the Health Summit may have been adversely effected.

Overall, one found the intervention to have been successful in that it described the health behaviors of the Savannah South District, it provided instruction on healthy lifestyles, and it analyzed respondent knowledge of the correct behaviors after the intervention.

Targeting Millennials in Replicating this Project

Another thing I would change would be to address the need to reach millennials. As the newest generation to reach adulthood, addressing their needs is imperative both for their health and for the growth of the church. Millennials have been characterized as the digital generation. And, as the first generation to be born and grow up in the age of technology, researchers posit that millennials learn best using digital platforms. With this in mind, replicating the IMPACT project for a sample of millennials would include having millennials as context associates and using a variety of digital platforms to advertise the project, conduct and track the classes, and evaluate the learning. For instance, Facebook, Twitter, or other such applications might serve as great tools for advertising. Classes might be taught using e-learning tools and technologies such as Captivate. Survey Monkey, Survey Gizmo, or other survey applications may be used to electronically evaluate learning. There are also a wide variety of learning management systems (LMSs) that combine all these features into one digital platform. These options could be explored among the millennial context associates for tools that are simple and efficient to use.

The Journey, the Thesis and the Project.

Two areas that were extremely beneficial on this journey were the Intensives and the Interim Focus Groups. The format of the Intensives was simple, yet noteworthy in that it brought us together, separated us into groups, and then brought us together again. We came together to worship and to learn. We started our day together in worship, regardless of our various ethnicities or denominations. We ended several of our evenings

together as well. This togetherness, and yes, synergy, was important for me because in so many venues it is one or the other: worship or learning.

The Intensives were just that – INTENSE! By that I mean that there was also so much going on, so much being learned, so many new friends, time was so compressed – it was awesome. This intensity was stress personified. However, it was not a time of distress, but one of eustress. Intensives were a time of coming together, learning new information, exploring new concepts and ideas, seeing and hearing other perspectives, and examining how all this new data fit into your context. Each session provided new "golden nuggets" for students to mine, put in their tool boxes, and take back to pull out, dust off, and reuse within their own time and space.

The Interim Focus Group sessions were just as important. Although they did not have the same hustle and bustle of the Intensives, in some ways they were the same. We came together to worship and to learn at our Interim Focus Groups just as we did at Intensives. We always learned a lot from our mentors. And we always enjoyed time with our peers.

In our Interim Focus Groups, our mentors, Dr. Kenneth Cummings and Dr. Robert Walker, used the time to help us understand the next steps for each peer group. They provided assessments of our work, went over the guidelines, and set realistic expectations for us to meet. Additionally, they spent time helping us to get a real-world understanding of what it meant to be in the Prophetic Preaching and Praxis Focus Group. They used real life examples of praxis each time we met. We visited several areas in Dayton, as well as in Charleston, Savannah, and Richmond, where peers were at work in their communities, putting their preaching and their projects to work in the community.

Our Interim Focus Groups were also filled with a variety of plenary sessions. Not only did our mentors provide instruction, but peers provided instructions as well. We were even blessed to have several guest instructors.

Another important aspect of the Interim Focus Group was that we were able to spend more one-on-one time with our mentors. Although they would dedicate sessions to reviewing the requirements for each peer group, it was always nice to have that face-to-face feedback from them. This time was particularly special for me because I am not one who will usually reach out for help. But during our Interim Focus Groups, time with the mentors was mandatory, and I was more likely to open up some then.

One of the things that I learned about myself on this journey was that although I am very social and very vocal in many ways, I am also quite introspective. I have always been this way, but not until now have I realized how difficult it can be for me to reach out for help. Ironically, this realization has helped me to reach out and check in more with my congregation. So, I am more out-going when it comes to helping others, but more introverted when it is for me. Weird, I know, but the blessing has been that my mentors have accepted me where I am and have helped me to fulfill my goals.

Another thing that I have learned is that I am not a quitter. Many, many times I have wanted to hang it up and stay home. Not another Intensive. Not another paper. Not another task piled onto an already overwhelming load. My journey has had so many hiccups. I have had two procedures, two major surgeries, two semesters that I had to sit out, many changes to my context, and many rewrites to my papers. But God is so good! I can truly say that He put his divine hand on my situation. He placed me in a focus group that I really did not want to be in at first. He put me with mentors and peers who accepted

me from another group as though I had been there all along. They loved me and nurtured me and they helped me grow. Were it not for my mentors, I might not be able to say that I am not a quitter. But I thank my God for them because as He strengthened me, they moved me along, sometimes pushing, sometimes through reminding me of my goals. But, Dr. Cummings and Dr. Walker never gave up on me and that helped me to not give up on myself.

As far as my project goes, I think my greatest joy has been that I was able to bring a project to the Savannah South District that was much needed and well received. My biggest disappointments in the project was that it took so long to get going and that it was held at a time that had so many other District commitments that attendance was much less than I expected. Overall though, I paraphrase a gospel song: "As I look back over my [project], and I think things over, I can truly say, that I've been blessed. I have a testimony!"

APPENDIX A

LETTER TO PRESIDING ELDER

September 5, 2016

Presiding Elder Mathis,

I greet you in the Holy name of our Lord and Savior Jesus Christ and pray that you and your family continue to be blessed.

Thank you for meeting with me and giving me your verbal approval to begin my Thesis project on the Savannah South District. As you are aware, I am in the Doctor of Ministry Program at United Theological Seminary in the Prophetic Preaching and Praxis Focus Group. The central theme of my thesis project is improving the health of Savannah South District pastors and congregants by providing tools that will engage pastors and their congregations in lifestyle management. I feel this to be a very timely project given the high rate of cardiovascular disease, obesity and chronic illness among African Americans, especially here in the South.

This letter is to formally request and document permission from you to work with pastors and churches across the Savannah South District and solicit their assistance with this project.

Although I will not be able to begin the project until I complete Candidacy Review this October, I need to begin the groundwork now. To that end, I will be in touch with several Savannah South District pastors and members to assist in the process.

Thank you for both your assistance and your support. Please feel free to call or email me should have any questions.

Yours in Christ,
Lic. *Cheryl Robinson*
St. Paul AMEC Blackcreek
(912)980-2834
76crobin@gmail.com

APPENDIX B

DEMOGRAPHIC QUESTIONNAIRE

Demographic Questionnaire

1. Age
In what year were you born? ____

2. What is your marital status?
o Now married
o Widowed
o Divorced
o Separated
o Never married
o Member of unmarried couple

3. What is the highest degree or level of school you have completed? If currently enrolled, what is the previous grade or highest degree received?
o No schooling completed
o Nursery school to 8th grade
o 9th, 10th or 11th grade
o 12th grade, no diploma
o High school graduate - high school diploma or the equivalent (for example: GED)
o Some college credit, but less than 1 year
o 1 or more years of college, no degree
o Associate degree (for example: AA, AS)
o Bachelor's degree (for example: BA, AB, BS)
o Master's degree (for example: MA, MS, MEng, MEd, MSW, MBA)
o Professional degree (for example: MD, DDS, DVM, LLB, JD)
o Doctorate degree (for example: PhD, EdD)

4. Employment Status
Are you currently?
o Employed for wages
o Self-employed
o Out of work and looking for work
o Out of work but not currently looking for work
o A homemaker
o A student
o Retired
o Unable to work

5. Employer Type
Please describe your work.
o Employee of a for-profit company or business or of an individual, for wages, salary, or commissions
o Employee of a not-for-profit, tax-exempt, or charitable organization
o Local government employee (city, county, etc.)
o State government employee

o Federal government employee
o Self-employed in own not-incorporated business, professional practice, or farm
o Self-employed in own incorporated business, professional practice, or farm
o Working without pay in family business or farm

6. Housing
Is this house, apartment, or mobile home?-
o Owned by you or someone in this household with a mortgage or loan
o Owned by you or someone in this household free and clear (without a mortgage or loan)
o Rented for cash rent
o Occupied without payment of cash rent

7. Household Income
What is your total household income (after taxes)?
o Less than $10,000
o $10,000 to $19,999
o $20,000 to $29,999
o $30,000 to $39,999
o $40,000 to $49,999
o $50,000 to $59,999
o $60,000 to $69,999
o $70,000 to $79,999
o $80,000 to $89,999
o $90,000 to $99,999
o $100,000 to $149,999
o $150,000 or more

8. Are you covered by health insurance or some other kind of health care plan?
o Yes
o No
o Refused
o Don’t know

9. What kind of health insurance or health care coverage do you have? Include those that pay for only one type of service (nursing home care, accidents, or dental care). Exclude private plans that only provide extra cash while hospitalized. If you have more than one kind of health insurance, tell me all plans that you have. Select all that apply. Do not allow more than one answer when no coverage of any type is selected.

o Private health insurance
o Medicare
o Medi-Gap
o Medicaid
o Military Health Care (Tricare/VA/Champ-VA)
o Indian Health Service

o State Sponsored Health Plan
o Other Government Program
o Single Service Plan (e.g. Dental Vision, Prescriptions)
o No Coverage of any Type
o Refused
o Don't Know

10. Race
Please specify your race.
o American Indian or Alaska Native
o Asian
o Black or African American
o Native Hawaiian or Other Pacific Islander
o White

10. Ethnicity
Please specify your ethnicity.
o Hispanic or Latino
o Not Hispanic or Latino

APPENDIX C

PRE-TEST SURVEY LAITY

Health Behaviors Survey - Laity

1. When you buy food, how important is the nutritional content to you?
a. Very important
b. Somewhat Important
c. Not important

2. When you buy food, how important is the ease of preparation?
a. Very important
b. Somewhat important
c. Not important

3. When you buy food, how important is the taste of the product?
a. Very important
b. Somewhat important
c. Not important

4. How many sodas per week do you usually drink?
a. none
b. 1-4
c. 5-7
d. 8 or more

5. How many times per week do you eat fast food?
a. never
b. 1-2
c. 3-4
d. 5 or more

6. How many time per week do you exercise (enough to break a sweat) for 30 or more minutes?
a. never
b. 1-2
c. 3-4
d. 5 or more

7. How important is a structured Physical Education Program at school to you as a parent?
a. Very important
b. Somewhat important

c. Not important

8. How many hours (off work) in total do you watch TV, use the computer or phone, or play video games on an average day?
a. none
b. Less than 1
c. 1-2
d. 3-4
e. 5 or more

9. Where would you most likely go to get help / advice regarding your health and fitness?
a. Family / Friends
b. Doctor's Office / Clinics
c. Pastor / Church Bulletin / Health Committee at Church
d. Local Gyms / Recreation Centers
e. The Internet

10. What are current barriers to keeping yourself healthy and fit? (check all that apply)
a. Lack of time
b. Lack of finances
c. Unaware of resources available
d. Lack of interest

11. When you exercise, what types of exercise do you most often do? (one only)
a. Running, walking, or swimming
b. Aerobic classes, dance or Zumba
c. Strength or weight training
d. Yoga or Tai chi

12. How many glasses of water do you consume per day?
a. none
b. 1-4
c. 5-7
d. 8 or more

13. What type of water do you consume most often?
a. Tap
b. Bottle
c. Flavored

14. How much salt/sodium do you believe you consume each day from all sources, including table salt, processed and canned foods, and from snack items?
a. Less than 2,300 milligrams per day
b. 2,300 milligrams to 3,400 milligrams per day
c. 3,400 milligrams to 4,000 milligrams per day
d. Greater than 4,000 milligrams per day

15. What is the average number of servings of fruit and vegetable you eat each day?
a. 1 to 2
b. 3 to 4
c. 5 or more

APPENDIX D

PRE-TEST SURVEY MINISTERS

Health Behaviors Survey - Ministers

1. When you buy food, how important is the nutritional content to you?
a. Very important
b. Somewhat Important
c. Not important

2. When you buy food, how important is the ease of preparation?
a. Very important
b. Somewhat important
c. Not important

3. When you buy food, how important is the taste of the product?
a. Very important
b. Somewhat important
c. Not important

4. How many sodas per week do you usually drink?
a. none
b. 1-4
c. 5-7
d. 8 or more

5. How many times per week do you eat fast food?
a. never
b. 1-2
c. 3-4
d. 5 or more

6. How many time per week do you exercise (enough to break a sweat) for 30 or more minutes?
a. never
b. 1-2
c. 3-4
d. 5 or more

7. How important is a structured Physical Education Program at school to you as a parent?
a. Very important
b. Somewhat important

c. Not important

8. How many hours (off work) in total do you watch TV, use the computer or phone, or play video games on an average day?
a. none
b. Less than 1
c. 1-2
d. 3-4
e. 5 or more

9. Where would you most likely go to get help / advice regarding your health and fitness?
a. Family / Friends
b. Doctor's Office / Clinics
c. Pastor / Church Bulletin / Health Committee at Church
d. Local Gyms / Recreation Centers
e. The Internet

10. What are current barriers to keeping yourself healthy and fit? (check all that apply)
a. Lack of time
b. Lack of finances
c. Unaware of resources available
d. Lack of interest

11. When you exercise, what types of exercise do you most often do? (one only)
a. Running, walking, or swimming
b. Aerobic classes, dance or Zumba
c. Strength or weight training
d. Yoga or Tai chi

12. How many glasses of water do you consume per day?
a. none
b. 1-4
c. 5-7
d. 8 or more

13. What type of water do you consume most often?
a. Tap
b. Bottle
c. Flavored

14. How much salt/sodium do you believe you consume each day from all sources, including table salt, processed and canned foods, and from snack items?
a. Less than 2,300 milligrams per day
b. 2,300 milligrams to 3,400 milligrams per day
c. 3,400 milligrams to 4,000 milligrams per day
d. Greater than 4,000 milligrams per day

15. What is the average number of servings of fruit and vegetable you eat each day?
a. 1 to 2
b. 3 to 4
c. 5 or more

16. How important is physical health to you?
a. Not at all
b. Somewhat important
c. Very Important

17. What do you believe to be the relationship between physical health and spiritual health?
a. The two types of health are not related to each other.
b. One must have physical health in order to have spiritual health.
c. One must have spiritual health in order to have physical health.
d. One must have both physical and spiritual health in order to be healthy.

18. Do you find it difficult to discuss health related issues with your congregation?
a. Not at all
b. Somewhat
c. Very

19. How often do you talk about health and/or health behaviors in your sermons?
a. Never
b. Once per quarter
c. Once per month
d. More than once per month

20. Do you believe you set an example of good health for your congregation?
a. No, I do not set an example of good health for my congregation.
b. I set a fair example of good health for my congregation.
c. I set a good example of good health for my congregation.
d. I set an excellent example of good health for my congregation.

APPENDIX E

POST-TEST SURVEY LAITY

Health Behaviors Post-Test – Laity

Thank you for participating in the IMPACT Health Summit. Please answer the following questions based on what you have learned during the various classes at the Health Summit.

1. Based on the classes, how important is the nutritional content of the foods you buy?
a. Very important
b. Somewhat Important
c. Not important

2. Based on the classes, how important is the ease of preparation of the foods you buy?
a. Very important
b. Somewhat important
c. Not important

3. Based on the classes, how important is the taste of the products you buy?
a. Very important
b. somewhat important
c. Not important

4. Based on the classes, how many sodas per week are you now likely to drink?
a. none
b. 1-4
c. 5-7
d. 8 or more

5. Based on the classes, how many times per week are you likely to eat fast food?
a. never
b. 1-2
c. 3-4
d. 5 or more

6. Based on the classes, how many time per week should you exercise (enough to break a sweat) for 30 or more minutes?
a. never
b. 1-2
c. 3-4
d. 5 or more

7. How important is a structured Physical Education Program at school to you as a parent?
a. Very important
b. Somewhat important
c. Not important

8. Based on the classes, how many hours (off work) in total should you watch TV, use the computer or phone, or play video games on an average day?
a. none
b. Less than 1
c. 1-2
d. 3-4
e. 5 or more

9. Based on the classes, where is the best source to get help / advice regarding your health and fitness?
a. Family / Friends
b. Doctor's Office / Clinics
c. Pastor / Church Bulletin / Health Committee at Church
d. Local Gyms / Recreation Centers
e. The Internet

10. What are current barriers to keeping yourself healthy and fit? (check all that apply)
a. Lack of time
b. Lack of finances
c. Unaware of resources available
d. Lack of interest

11. Based on the classes, what types of exercise are you making an exercise plan to do? (one only)
a. Running, walking, or swimming
b. Aerobic classes, dance or Zumba
c. Strength or weight training
d. Yoga or Tai chi

12. Based on the classes, how many glasses of water should you consume per day?
a. none
b. 1-4
c. 5-7
d. 8 or more

13. What type of water do you consume most often?
a. Tap
b. Bottle
c. Flavored

14. Based on the classes, how much salt/sodium should you consume each day from all sources, including table salt, processed and canned foods, and from snack items?
a. Less than 2,300 milligrams per day
b. 2,300 milligrams to 3,400 milligrams per day
c. 3,400 milligrams to 4,000 milligrams per day
d. Greater than 4,000 milligrams per day

15. Based on the classes, what is the average number of servings of fruit and vegetable you should eat each day?
a. 1 to 2
b. 3 to 4
c. 5 or more

APPENDIX F

POST TEST SURVEY MINISTERS

Health Behaviors Post-Test – Ministers

Thank you for participating in the IMPACT Health Summit. Please answer the following questions based on what you have learned during the various classes at the Health Summit.

1. Based on the classes, how important is the nutritional content of the foods you buy?
a. Very important
b. Somewhat Important
c. Not important

2. Based on the classes, how important is the ease of preparation of the foods you buy?
a. Very important
b. Somewhat important
c. Not important

3. Based on the classes, how important is the taste of the products you buy?
a. Very important
b. somewhat important
c. Not important

4. Based on the classes, how many sodas per week are you now likely to drink?
a. none
b. 1-4
c. 5-7
d. 8 or more

5. Based on the classes, how many times per week are you likely to eat fast food?
a. never
b. 1-2
c. 3-4
d. 5 or more

6. Based on the classes, how many time per week should you exercise (enough to break a sweat) for 30 or more minutes?
a. never
b. 1-2
c. 3-4
d. 5 or more

7. How important is a structured Physical Education Program at school to you as a parent?
a. Very important
b. Somewhat important
c. Not important

8. Based on the classes, how many hours (off work) in total should you watch TV, use the computer or phone, or play video games on an average day?
a. none
b. Less than 1
c. 1-2
d. 3-4
e. 5 or more

9. Based on the classes, where is the best source to get help / advice regarding your health and fitness?
a. Family / Friends
b. Doctor's Office / Clinics
c. Pastor / Church Bulletin / Health Committee at Church
d. Local Gyms / Recreation Centers
e. The Internet

10. What are current barriers to keeping yourself healthy and fit? (check all that apply)
a. Lack of time
b. Lack of finances
c. Unaware of resources available
d. Lack of interest

11. Based on the classes, what types of exercise are you making an exercise plan to do? (one only)
a. Running, walking, or swimming
b. Aerobic classes, dance or Zumba
c. Strength or weight training
d. Yoga or Tai chi

12. Based on the classes, how many glasses of water should you consume per day?
a. none
b. 1-4
c. 5-7
d. 8 or more

13. What type of water do you consume most often?
a. Tap
b. Bottle
c. Flavored

14. Based on the classes, how much salt/sodium should you consume each day from all sources, including table salt, processed and canned foods, and from snack items)?
a. Less than 2,300 milligrams per day
b. 2,300 milligrams to 3,400 milligrams per day
c. 3,400 milligrams to 4,000 milligrams per day
d. Greater than 4,000 milligrams per day

15. Based on the classes, what is the average number of servings of fruit and vegetable you eat each day?
a. 1 to 2
b. 3 to 4
c. 5 or more

16. How important is physical health to you?
a. Not at all
b. Somewhat important
c. Very Important

17. Based on the classes, what do you believe to be the relationship between physical health and spiritual health?
a. The two types of health are not related to each other.
b. One must have physical health in order to have spiritual health.
c. One must have spiritual health in order to have physical health.
d. One must have both physical and spiritual health in order to be healthy.

18. Since participating in the classes, do you believe you will find it difficult to discuss health-related issues with your congregation?
a. Not at all
b. Somewhat
c. Very

19. Based on the classes, how often should you talk about health and/or health behaviors in your sermons?
a. Never
b. Once per quarter
c. Once per month
d. More than once per month

20. Based on the classes, do you believe you will be able to set an example of good health for your congregation?

a. No, I do not believe I will be able to set an example of good health for my congregation.

b. I believe I will be able to set a fair example of good health for my congregation.

c. I believe I will be able to set a good example of good health for my congregation.

d. I believe I will be able to set an excellent example of good health for my congregation.

APPENDIX G

TELEPHONE INTERVIW QUESTIONNAIRE

Healthy Behaviors Telephone Interview

1. What measures do you use to maintain your health?
2. How often and what type of exercise do you do on a weekly basis?
3. How much water do you drink on a daily basis?
4. How many servings of fruits and vegetables do you eat on a daily basis?
5. How much salt/sodium do you consume on a daily basis? (Interviewer may provide examples of sodium-rich foods such as canned goods, frozen and prepared foods, cold cuts/luncheon meats, cheeses, soups, nuts, breads and rolls, and chips and other salty snacks).

APPENDIX H

SCRIPTURES ON HEALTH TOPICS FOR SERMONS

Sample Scriptures for Sermons Related to Health Behaviors

Increase Exercise/Walk(ing)

1 Timothy 4:7-8 "Have nothing to do with profane myths and old wives' tales. Train yourself in godliness, for, while physical training is of some value, godliness is valuable in every way, holding promise for both the present life and the life to come." (NRSV)

1 Corinthians 9:24-26 "Do you not know that in a race the runners all compete, but only one receives the prize? Run in such a way that you may win it. Athletes exercise self-control in all things; they do it to receive a perishable wreath, but we an imperishable one. So I do not run aimlessly, nor do I box as though beating the air;" (NRSV)

Judges 5:5-7 "The mountains gushed before the Lord, This Sinai, before the Lord God of Israel. In the days of Shamgar, son of Anath, In the days of Jael, the highways were deserted, And the travelers walked along the byways. Village life ceased, it ceased in Israel, Until I, Deborah, arose, Arose a mother in Israel." (NKJV)

Job 1:6-8 "Now there was a day when the sons of God came to present themselves before the Lord, and Satan[a] also came among them. And the Lord said to Satan, 'From where do you come?' So Satan answered the Lord and said, 'From going to and fro on the earth, and from walking back and forth on it.' Then the Lord said to Satan, 'Have you considered My servant Job, that there is none like him on the earth, a blameless and upright man, one who fears God and shuns evil?'" (KJV)

Psalm 15:1-3 "Lord, who may abide in Your tabernacle? Who may dwell in Your holy hill? He who walks uprightly, And works righteousness, And speaks the truth in his heart; He who does not backbite with his tongue, Nor does evil to his neighbor, Nor does he take up a reproach against his friend;" (NKJV)

Psalm 23:4-5 "Yea, though I walk through the valley of the shadow of death, I will fear no evil; For You are with me; Your rod and Your staff, they comfort me. You prepare a table before me in the presence of my enemies; You anoint my head with oil; My cup runs over." (NKJV)

Psalm 48:11-13 "Let Mount Zion rejoice, Let the daughters of Judah be glad, Because of Your judgments. Walk about Zion, And go all around her. Count her towers; Mark well her bulwarks; Consider her palaces; That you may tell *it* to the generation following." (NKJV)

Proverbs 4:11-13 "I have taught you in the way of wisdom; I have led you in right paths. When you walk, your steps will not be hindered, And when you run, you will not stumble. Take firm hold of instruction, do not let go; Keep her, for she *is* your life." (NKJV)

Isaiah 40:30-31 "Even the youths shall faint and be weary, And the young men shall utterly fall, But those who wait on the Lord Shall renew *their* strength; They shall mount up with wings like eagles, They shall run and not be weary, They shall walk and not faint." (NKJV)

Increase Fruits and Vegetables

Genesis 1:29 "And God said, Behold, I have given you every herb bearing seed, which [is] upon the face of all the earth, and every tree, in the which [is] the fruit of a tree yielding seed; to you it shall be for meat." (KJV)

Joshua 5:11-12 "And they did eat of the old corn of the land on the morrow after the passover, unleavened cakes, and parched corn in the selfsame day. And the manna ceased on the morrow after they had eaten of the old corn of the land; neither had the children of Israel manna any more; but they did eat of the fruit of the land of Canaan that year." (KJV)

2 Kings 19:29 "And this shall be a sign unto thee, Ye shall eat this year such things as grow of themselves, and in the second year that which springeth of the same; and in the third year sow ye, and reap, and plant vineyards, and eat the fruits thereof." (KJV)

Proverbs 15:16-18 "Better a little with the fear of the Lord than great wealth with turmoil. Better a small serving of vegetables with love than a fattened calf with hatred. A hot-tempered person stirs up conflict, but the one who is patient calms a quarrel. (NIV)

Daniel 1:11-13 "Daniel then said to the guard whom the chief official had appointed over Daniel, Hananiah, Mishael and Azariah, "Please test your servants for ten days: Give us nothing but vegetables to eat and water to drink. Then compare our appearance with that of the young men who eat the royal food, and treat your servants in accordance with what you see." (NIV)

Nehemiah 9:35-37 "Even while they were in their kingdom, enjoying your great goodness to them in the spacious and fertile land you gave them, they did not serve you or turn from their evil ways. "But see, we are slaves today, slaves in the land you gave our ancestors so they could eat its fruit and the other good things it produces. Because of our sins, its abundant harvest goes to the kings you have placed over us. They rule over our bodies and our cattle as they please. We are in great distress." (NIV)

Jeremiah 2:7-8 "I brought you into a plentiful land to eat its fruits and its good things. But when you entered you defiled my land, and made my heritage an abomination. The priests did not say, 'Where is the Lord?' Those who handle the law did not know me; the rulers transgressed against me; the prophets prophesied by Baal, and went after things that do not profit." (NRSV)

Increase Water

John 4: 10-15 "Jesus answered and said unto her, If thou knewest the gift of God, and who it is that saith to thee, Give me to drink; thou wouldest have asked of him, and he would have given thee living water. The woman saith unto him, Sir, thou hast nothing to draw with, and the well is deep: from whence then hast thou that living water? Art thou greater than our father Jacob, which gave us the well, and drank thereof himself, and his children, and his cattle? Jesus answered and said unto her, Whosoever drinketh of this water shall thirst again: But whosoever drinketh of the water that I shall give him shall never thirst; but the water that I shall give him shall be in him a well of water springing up into everlasting life. The woman saith unto him, Sir, give me this water, that I thirst not, neither come hither to draw." (KJV)

Exodus 17:5-7 "The Lord answered Moses, 'Go out in front of the people. Take with you some of the elders of Israel and take in your hand the staff with which you struck the Nile, and go. I will stand there before you by the rock at Horeb. Strike the rock, and water will come out of it for the people to drink.' So Moses did this in the sight of the elders of Israel. And he called the place Massah and Meribah because the Israelites quarreled and because they tested the Lord saying, 'Is the Lord among us or not?' And he called the name of the place Massah, and Meribah, because of the chiding of the children of Israel, and because they tempted the Lord, saying, Is the Lord among us, or not?" (NIV)

Judges 7:5-7 "So he brought down the people unto the water: and the Lord said unto Gideon, Every one that lappeth of the water with his tongue, as a dog lappeth, him shalt thou set by himself; likewise every one that boweth down upon his knees to drink. And the number of them that lapped, putting their hand to their mouth, were three hundred men: but all the rest of the people bowed down upon their knees to drink water. And the Lord said unto Gideon, By the three hundred men that lapped will I save you, and deliver the Midianites into thine hand: and let all the other people go every man unto his place."

1 Kings 19:5-7 "And as he lay and slept under a juniper tree, behold, then an angel touched him, and said unto him, Arise and eat. And he looked, and, behold, there was a cake baken on the coals, and a cruse of water at his head. And he did eat and drink, and laid him down again. And the angel of the Lord came again the second time, and touched him, and said, Arise and eat; because the journey is too great for thee." (KJV)

Isaiah 43:19-21 "Behold, I will do a new thing; now it shall spring forth; shall ye not know it? I will even make a way in the wilderness, and rivers in the desert. The beast of the field shall honour me, the dragons and the owls: because I give waters in the wilderness, and rivers in the desert, to give drink to my people, my chosen. This people have I formed for myself; they shall shew forth my praise." (KJV)

Mark 9:41 "For whosoever shall give you a cup of water to drink in my name, because ye belong to Christ, verily I say unto you, he shall not lose his reward." (KJV)

Decrease Salt

Matthew 5:13-16 “You are the salt of the earth; but if salt has lost its taste, how can its saltiness be restored? It is no longer good for anything, but is thrown out and trampled under foot. You are the light of the world. A city built on a hill cannot be hid. No one after lighting a lamp puts it under the bushel basket, but on the lampstand, and it gives light to all in the house. In the same way, let your light shine before others, so that they may see your good works and give glory to your Father in heaven.” (NRSV)

Genesis 19:25-26 and he overthrew those cities, and all the Plain, and all the inhabitants of the cities, and what grew on the ground. But Lot’s wife, behind him, looked back, and she became a pillar of salt. (NRSV)

Deuteronomy 29:22-23 “The next generation, your children who rise up after you, as well as the foreigner who comes from a distant country, will see the devastation of that land and the afflictions with which the Lord has afflicted it all its soil burned out by sulfur and salt, nothing planted, nothing sprouting, unable to support any vegetation, like the destruction of Sodom and Gomorrah, Admah and Zeboiim, which the Lord destroyed in his fierce anger.” (NRSV)

Judges 9:45 “Abimelech fought against the city all that day; he took the city, and killed the people that were in it; and he razed the city and sowed it with salt.” (NRSV)

Psalm 107:33-35 “He turns rivers into a desert, springs of water into thirsty ground, a fruitful land into a salty waste, because of the wickedness of its inhabitants. He turns a desert into pools of water, a parched land into springs of water.” (NRSV

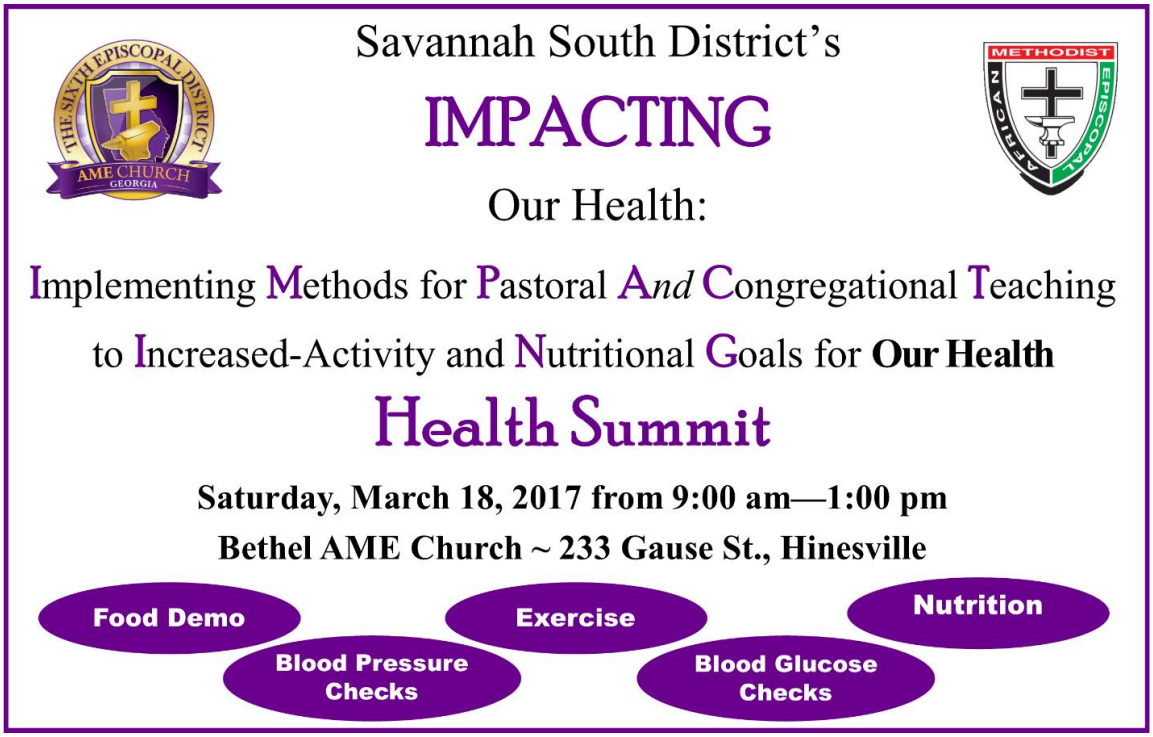
Jeremiah 17:5-6 “Thus says the Lord: Cursed are those who trust in mere mortals and make mere flesh their strength, whose hearts turn away from the Lord. They shall be like a shrub in the desert, and shall not see when relief comes. They shall live in the parched places of the wilderness, in an uninhabited salt land.” (NRSV)

Matthew 5:12-13 “Rejoice and be glad, for your reward is great in heaven, for in the same way they persecuted the prophets who were before you. You are the salt of the earth; but if salt has lost its taste, how can its saltiness be restored? It is no longer good for anything, but is thrown out and trampled under foot.” (NRSV)

James 3:11-13 “Does a spring pour forth from the same opening both fresh and brackish water? Can a fig tree, my brothers and sisters, yield olives, or a grapevine figs? No more can salt water yield fresh.” (NRSV)

APPENDIX I

HEALTH SUMMIT FLYER


Savannah South District's
IMPACTING
Our Health:
Implementing Methods for Pastoral And Congregational Teaching
to Increased-Activity and Nutritional Goals for Our Health
Health Summit
Saturday, March 18, 2017 from 9:00 am—1:00 pm
Bethel AME Church ~ 233 Gause St., Hinesville
Food Demo
Exercise
Nutrition
Blood Pressure Checks
Blood Glucose Checks

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